LOS ANGELES COUNTY
COMMISSION ON HIV

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SAVE THE DATE

EXECUTIVE COMMITTEE
Virtual Meeting

Monday, November 30, 2020*
2:00PM - 4:00PM (PST)

***The regularly scheduled November and December meetings have been consolidated into one meeting on November 30 to accommodate holiday schedules. The meeting agenda and packet will be forthcoming and available on our website at www.hiv.lacounty.gov ***

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AGENDA FOR THE **VIRTUAL** MEETING OF THE
LOS ANGELES COUNTY COMMISSION ON HIV (COH)
EXECUTIVE COMMITTEE

Monday, November 30, 2020 @ 2:00 P.M.–4:00 P.M.

To Join by Computer, please Register at:
https://tinyurl.com/y5n3fswe
**link is for non-Committee members + members of the public*

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Executive Committee Members:			
Al Ballesteros, MBA, Co-Chair	*Bridget Gordon, Co-Chair*	Raquel Cataldo	Michele Daniels (Exec At-Large)
Erika Davies	Joseph Green	Lee Kochems, MA	Katja Nelson, MPP
Mario Perez, MPH	Juan Preciado	Kevin Stalter	Justin Valero (Exec, At-Large)
QUORUM*:	**7**		

Due to COVID-19, quorum requirements suspended for teleconference meetings per Governor Newsom's Executive Order N-25-20

AGENDA POSTED: November 23, 2020

ATTENTION: Any person who seeks support or endorsement from the Commission or Committee on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these services, please contact the Commission office at (213) 738-2816 or via email at hivcomm@lachiv.org.

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SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of

the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of a meeting. If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests—from members or other stakeholders—within the limitations and requirements of other possible constraints.

Call to Order, Introductions, and Conflict of Interest Statements 2:00 P.M. – 2:03 P.M.

I. ADMINISTRATIVE MATTERS

1.	Approval of Agenda	**MOTION # 1**	2:03 P.M. – 2:05 P.M.
2.	Approval of Meeting Minutes	**MOTION # 2**	2:05 P.M. – 2:07 P.M.

II. PUBLIC COMMENT 2:07 P.M. – 2:10 P.M.

3. Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission.

III. COMMITTEE NEW BUSINESS ITEMS 2:10 P.M. – 2:13 P.M.

4. Opportunity for Committee members to recommend new business items for the full body or a committee level discussion on non-agendized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.

IV. REPORTS

5. Executive Director's/Staff Report 2:13 P.M. – 2:30 P.M.

A. Commission/County Operational Updates
B. Ending the HIV Epidemic and Commission Activities
C. IHAP Technical Assistance to Assess Planning Council Effectiveness
D. RWHAP Part A Planning Councils Recruitment and Retention Learning Collaborative Opportunity

6. Co-Chair's Report 2:30 P.M. – 3:00 P.M.

A. Annual Meeting Follow Up & Feedback
   a. Code of Conduct Review & Compliance
   b. Strategies to Address Biases and Racial Disparities
   c. Take Me Home (TMH) Test Kit Program

B. 2021 Committee Open Nomination + Elections Preparation

C. At Large Executive Committee Member Open Nominations | REMINDER+ONGOING

7. Division of HIV and STD Programs (DHSP) Report 3:00 P.M. – 3:10 P.M.

A. Fiscal, Programmatic and Procurement Updates

B. Ending the HIV Epidemic (EHE) Activities + Update

8. Standing Committee Reports: 3:10 P.M. – 3:45 P.M.

A. Operations Committee
   (1) Membership Management
   - New Member Applicant Interviews
   - New Member Applications:
     - Alexander Luckie Fuller **MOTION #3**
     - Guadalupe Velazquez **MOTION #4**
     - Ernest Walker **MOTION #5**
   - Resignation | Aaron Fox

   (2) 2020 Virtual Training Summary
   (3) Mentorship Program Update

B. Planning, Priorities and Allocations (PP&A) Committee
   (1) DHSP Fiscal Updates
   (2) Prevention Planning

C. Standards and Best Practices (SBP) Committee
   (1) Child Care Standards of Care Update
   (2) Universal Standards of Care Update
   (3) Patient Bill of Rights

D. Public Policy Committee
   (1) Collaboration w/ BAAC Task Force
   (2) Meth & HIV
   (3) County, State and Federal Policy and Legislation
   (4) County, State and Federal Budget

9. Caucus, Task Force, and Work Group Reports: 3:45 P.M. – 3:50 P.M.

A. Aging Task Force | December 7, 2020 @ 9:30am-11:30am
   (1) Draft Recommendations Review

B. Black/African-American Community (BAAC) Task Force | December 2, 2020 @ 1-3pm

C. Consumer Caucus | December 10, 2020; time TBD

D. Women's Caucus | January 18, 2021 @ 2-4pm

E. Transgender Caucus | December 2, 2020 @ 10am-12pm

V. NEXT STEPS

10. Task/Assignments Recap 3:50 P.M. – 3:53 P.M.

11. Agenda development for the next meeting 3:53 P.M. – 3:55 P.M.

VI. ANNOUNCEMENTS 3:55 P.M. – 4:00 P.M.

12. Opportunity for members of the public and the committee to make announcements

VII. ADJOURNMENT

13. Adjournment for the meeting of November 30, 2020. 4:00 P.M.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve the Executive Committee minutes, as presented or revised.
MOTION #3:	Approve New Member Applicant, Alexander Luckie Fuller and elevate to December 10, 2020 COH meeting for approval, as presented or revised.
MOTION #4:	Approve New Member Applicant, Guadalupe Velazquez and elevate to December 10, 2020 COH meeting for approval, as presented or revised.
MOTION #5:	Approve New Member Applicant, Ernest Walker, and elevate to December 10, 2020 COH meeting for approval, as presented or revised.

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HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov ORG • *VIRTUAL WEBEX MEETING*

Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

EXECUTIVE COMMITTEE MEETING MINUTES

September 24, 2020

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Bridget Gordon, *Co-Chair*	Al Ballesteros, MBA, *Co-Chair*	Danielle Campbell, MPH	Cheryl Barrit, MPIA
Raquel Cataldo	Michele Daniels	Geneviéve Clavreul, RN, PhD	Carolyn Echols-Watson, MPA
Erika Davies	Lee Kochems, MA	Kevin Donnelly	AJ King, MPH
Joseph Green	Juan Preciado	Jennifer Gjurashaj	Dawn McClendon
Katja Nelson, MPP		Carlos Moreno	Jane Nachazel
Mario Pérez, MPH	**DHSP STAFF**	LCDR Jose Antonio Ortiz, MPH	
Kevin Stalter	Julie Tolentino, MPH		

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.

CONTENTS OF COMMITTEE PACKET

1) **Cover Page**: Executive Committee Virtual Meeting, *9/24/2020*
2) **Agenda**: Executive Committee Meeting Agenda, *9/24/2020*
3) **Code**: Code of Conduct, *4/11/2019*
4) **Statement**: To End HIV, We Must End Racism, *2020*
5) **Minutes**: Executive Committee Meeting Minutes, *8/27/2020*
6) **Schedule**: Virtual Training Schedule for Commissioners and Community Members, *2020*
7) **Policy/Procedure**: #09.7201: Compensation for Unaffiliated Consumer Commission Members, *4/12/2012, Draft updates 9/15/2020*
8) **Summary**: Possible Commission on HIV Ending the HIV Epidemic Activities and 2020 Annual Meeting Ideas, For Executive Committee Discussion Only, Draft, *9/24/2020*
9) **Report**: Supplement to the Assessment of the Administrative Mechanism, Report Prepared for the Los Angeles County Commission on HIV, *February 2020*
10) **Roster**: 2020 Membership Roster, *Updated 8/24/2020*
11) **Table**: Planning Council/Planning Body Reflectiveness, *Updated 9/16/2020*
12) **Membership Application**: Everardo Alvizo, *9/4/2020*
13) **Directives**: Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32, *Proposed 9/24/2020*
14) **Recommendations**: (REVISED) Black/African American Community (BAAC) Task Force Recommendations, *10/10/2019*
15) **Public Comment**: Public Policy Committee, Public Comment Submitted to Housing Saves Lives Regarding Proposed Rule Change by HUD and Denying Access to Housing for Transgender Individuals, *9/24/2020*
16) **Statement**: End the Epidemics Racial Justice Working Group Condemns Police Brutality and White Supremacist Violence, *9/22/2020*
17) **Summary**: Aging Task Force, Virtual Meeting Summary, *8/3/2020*

18) **Summary**: Black African American Community (BAAC) Task Force, Virtual Meeting Summary, *8/10/2020*
19) **Flyer**: Virtual Lunch & Learn Series: Share, Learn, and Sustain Our HIV Movement; Women + HIV, A Special 4-Part Conversation; October 14, 2020, 12:00-1:30 pm, Women + HIV: Addressing Economic + Housing Insecurity; November 10, 2020, 12:00-1:30 pm, Women + HIV: The Impact of Trauma; *2020*

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST: Ms. Gordon called the meeting to order at 1:09 pm.

I. ADMINISTRATIVE MATTERS

1. **APPROVAL OF AGENDA**
MOTION #1: Approve the Agenda Order, as presented ***(Passed by Consensus)***.

2. **APPROVAL OF MEETING MINUTES**
MOTION #2: Approve the 8/27/2020 Executive Committee Meeting Minutes, as presented ***(Passed by Consensus)***.

II. PUBLIC COMMENT

3. **OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION**: There were no comments.

III. COMMITTEE NEW BUSINESS ITEMS

4. **OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA**: There were no items.

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**

A. Commission/County Operational Updates
- Ms. Barrit reported Sonja Wright, MS, Lac was still deployed on a Disaster Services Worker (DSW) assignment as part of a COVID-19 contact tracing team. She was able to join the 9/23/2020 Staff Meeting so staff is able to keep in touch.
- Questions continue to come from Commissioners and community members on when in-person Commission meetings might resume. Ms. Barrit acknowledged the concern, but reported there had been no change since the last update. Virtual meetings were expected to continue for the immediate future following Executive Office safety guidelines.

B. 2020 Commission Training Schedule - REMINDER
- Ms. Barrit thanked the Commission and Committee Co-Chairs for their work on the virtual training series. Attendance, including of new Commissioners and members of the public, has been good for the first two held in September.
- Operations Committee Co-Chairs Green and Preciado will lead the next training on Membership Structure and Responsibilities. That training will be 10/1/2020 at 10:00 to 11:30 am.
- The schedule was in the packet and all were encouraged to invite anyone who might be interested in the Commission.

C. 2020 Presidential Election Assistance
- Ms. Barrit had sent an email with a very short turnaround on volunteering to work the election. Five Commissioners replied they had signed up and were contacted by the Los Angeles County (LAC) Clerk's Office or were considering it. The need is great this year. There are many volunteer roles available and it is a fruitful experience to participate.
- Ms. McClendon has volunteered to represent the staff as a DSW over the five days of the election.

D. Unaffiliated Consumer (UCs) Member Stipends
- The pertinent Policy/Procedure was in the packet. Commission Bylaws permit eligible Commissioners or Alternates filling a Commissioner's role to earn a monthly stipend of $150 if they fulfill the stipend requirements. Eligible Alternates may earn a monthly stipend of $100 if they fulfill the stipend requirements.
- Stipend requirements are attendance at the full Commission, the assigned Committee, and the Consumer Caucus.
- Only Unaffiliated Consumers (UCs) are eligible. A UC is a PLWH who receives services from a Ryan White Part A-funded provider, but is not an officer, employee, or consultant of any Ryan White Part A-funded provider.
- Increasing stipends to the limits allowed in the Bylaws fulfills a longstanding consumer request.

E. Ending the HIV Epidemic (EHE) and Commission Activities

- A number of Commissioners participated in the EHE Town Hall hosted by DHSP on 9/16/2020. The Commission has also had several conversations regarding Year 1, and perhaps Year 2, initial community engagement activities. Based on that input, Ms. Barrit drafted ideas as noted in the summary document in the packet which she reviewed.
- She especially urged everyone to read the 24-page draft EHE Plan. DHSP needs to submit it by 10/16/2020. Comments can be submitted to Ms. Barrit for compilation and submission to DHSP or can be submitted independently.
- Mr. Green suggested using the proposed community engagement consultant to facilitate listening sessions in the various Service Planning Areas (SPAs) like those held some years ago.
- He also suggested a joint Executive Committee and Steering Committee meeting to enhance coordination. Ms. Nelson also asked if people could listen in to Steering Committee meetings even though they were not participants.
- ➲ Commissioners with EHE Plan comments for compilation by Ms. Barrit should submit them to her by 10/10/2020.
- ➲ Ms. Barrit also encouraged feedback to her on the proposed activities so she can incorporate it into the document for further discussion at the 10/8/2020 Commission meeting.
- ➲ Ms. Barrit will follow-up on a request from Mr. Green to evaluate potential Technical Assistance (TA) available for leadership development. Options include the Prevention through Active Community Engagement (PACE) Program and the National Association of State and Territorial AIDS Directors (NASTAD).

F. Annual Meeting Preparation

- Ms. Barrit noted the 11/12/2020 Annual Meeting was fast approaching, but final planning is usually done about now to ensure timely topics. Suggestions drawn from the past year's discussions were at the end of the previous document.
- The assumption is that the format will be virtual. Annual Meetings have generally run all day, but the average 9:00 am to 1:00 pm length of recent virtual Commission meetings is already pretty long for this format so may be preferable. Considerations include community participation and Commissioner commitment.
- She reviewed aspects of a suggested EHE theme of A Countywide Call to Action starting with the usual welcome and recap and meaningful time for a presentation by our DHSP partners perhaps on the impact of COVID-19. Ms. Gordon felt life with COVID-19 was a critical issue. Mr. Stalter also suggested evaluating changes prompted by the COVID-19 pandemic such as telehealth and how expended use of the format can help retention in care.
- Last year's Annual Meeting featured two panel discussions on integrative health services. An update with Departments of Mental Health (DMH), Public Health (DPH), and Health Services (DHS) could be very pertinent to health care now.
- Another option would highlight creating spaces for meaningful intergenerational conversations. Mr. Green considered this an important conversation since about half of the existing epidemic is in men over 50 while the emerging epidemic is largely in young men of color. A conversation of what was, what is, and where we're going needs to be addressed.
- The LAC Board of Supervisors (Board) also launched an Anti-Racism Initiative this year so the Commission might choose to address elevating HIV in countywide anti-racist policies consistent with the Black African American Community (BAAC) Task Force recommendations. Ms. Gordon supported addressing issues of race and equity. Ms. Nelson added that the Anti-Racism Initiative should provide a lens regardless of the specific topic.
- Mr. Donnelly suggested addressing coordination and expectations of the key historical plans: Comprehensive HIV Plan (CHP), Los Angeles County HIV/AIDS Strategy (LACHAS), and EHE.
- ➲ Additional Annual Meeting suggestions can be emailed to Ms. Barrit for incorporation into the document for further discussion at the 10/8/2020 Commission meeting.

6. CO-CHAIR REPORT

A. 9/10/2020 Commission Meeting Feedback: Ms. Nelson felt the Los Angeles Homeless Services Authority (LAHSA) presentation was important and highlighted areas to address. She looked forward to responses to questions raised.

B. 10/8/2020 Commission Meeting Agenda

- Ms. Barrit noted several people have asked for a presentation on COVID-19 research. She thanked Ms. Campbell for arranging to have Eric Daar, MD, Investigator, Lundquist Institute, present on his vaccine study.
- Time will also be reserved to ensure ample opportunity for community feedback on the EHE Plan.
- ➲ Disseminate flyer highlighting the two aforementioned meeting topics and the Commission's desire for feedback.

C. Board Letter Regarding Contractual Process - UPDATE

- Commission Co-Chairs Gordon and Ballesteros now have regular updates with DPH leadership on this issue. While progress is not as fast as Ms. Gordon would like, the Commission has been holding DPH leadership attention on it.

- Ms. Nelson asked if DPH offered any new information on why the process cannot be expedited. Ms. Gordon reported nothing new overall. Some miscommunications within DPH about the process and who was handling it had an impact.
- Co-Chairs Gordon and Ballesteros continue to keep the pressure on so DPH is aware the issue will not be ignored.

D. 2021 Co-Chair Open Nominations and Election – Election: 10/8/2020

- Mr. Ballesteros has been nominated, but was still considering whether or not to accept.
- ➲ Nominations of oneself or other Commissioners can be submitted to staff.

E. At-Large Executive Committee Member Open Nominations - REMINDER + ONGOING

- There are three total At-Large Executive Committee seats. At-Large Members also sit on the Operations Committee. Ms. Daniels sits on one seat. The other two are vacant. Nominees must be full Commissioners for at least one year.
- Two people were nominated at the last Commission Meeting, but both have since declined.
- ➲ Nominations of oneself or other Commissioners can be submitted to staff.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT

A. Fiscal, Programmatic, and Procurement Updates

- Mr. Pérez said DHSP has reviewed spending, priorities, and grants over the past few weeks and there is little new.
- The Request for Proposals (RFP) for community engagement has completed DHSP and Bureau review. It had moved on to the joint County Counsel and Contracts and Grants (C&G) review prior to DPH final sign-off.
- Emergency Financial Assistance (EFA) services will likely launch by November with at least one of the two providers.
- Regarding potential cuts, Mr. Pérez noted DHSP funds hundreds of contracts in a couple of dozens service categories. There were no anticipated federal cuts to grant levels now, but some programs were underspending and were being reviewed for possible reductions starting in July 2021. That review pertains to biomedical prevention efforts.
- Ms. Gordon asked about any updates or roadblocks regarding the DPH contracting process. Mr. Pérez reported DPH has been clear in its commitment to the Commission Co-Chairs and Ms. Barrit to move things as quickly as possible. DHSP will do all it can to support that, but he knew many C&G staff were redeployed as DSWs. He will advise if there are undue delays. He supported the Commission continuing to make clear in meetings with DPH that it is watching progress. DPH has also committed to twice monthly meetings between himself and Jeffrey Gunzenhauser, MD, MPH.
- Ms. Nelson asked if there were testing or treatment indicators that should be tracked. Mr. Pérez was sorry to report LAC was on track to have in excess of 120 congenital syphilis cases in 2020. Syphilis cases reported overall continue to rise including among groups historically impacted and women, particularly women of color. The Bureau is aware of the trend and DHSP was developing a memorandum on the topic to DPH Director Barbara Ferrer, PhD, MPH, Med and County Health Officer Montu Davis, MD, MPH to ensure awareness of the projected increase over last year.
- DHSP will also share that information with the Board as part of its quarterly STD update.
- On a related matter, there has been a drop in overall STD screening including among STD clinics operated by DPH. In some cases, clinics have closed and staff were redeployed to COVID-19. There are competing public health issues.
- A DHSP team follows up with all cases among women, including pregnant women, to intervene as quickly as possible.
- ➲ DHSP will forward the latest STD dashboard data to staff by 9/25/2020. In addition to the Commission Co-Chairs, data will be forwarded to the Public Policy Co-Chairs for review at the 10/5/2020 Committee Meeting to inform consideration of STD letter revisions. Finalization of the letter was postponed due to the focus on COVID-19.

B. Ending the HIV Epidemic (EHE) Activities and Updates

- Ms. Tolentino reported 251 people registered to attend DHSP's 9/16/2020 EHE Town Hall and 167 participated including 16 Commissioners and staff. Mr. Pérez offered opening remarks, she provided an overview of DHSP's EHE Initiative, and Medical Director Sonali Kulkarni, MD, MPH ended with a question/answer period. Slides were available.
- The first Steering Committee Meeting will be 10/1/2020. The Commission Co-Chairs and Ms. Barrit were invited to offer a Commission overview to inform the Committee on its HIV prevention and treatment roles and responsibilities and how it relates to EHE. The Committee agenda was uploaded to the screen and Ms. Tolentino reviewed members and their organizations. DHSP has intentionally reached out to the nontraditional sector to broaden voices.
- Mr. Green did not note any UC members. Ms. Tolentino replied DHSP's Committee questionnaire asked people about their serostatus and, if HIV+, if they were willing to self-disclose. Two did self-disclose and one is not affiliated. That person is a recent MPH graduate of the organization. Persons do not necessarily represent organizations listed.

- Regarding an earlier question, there has been no determination whether meetings overall will be open to public participation or attendance. The first meeting will be closed and many will be very action-oriented. However, DHSP could open up some specific meetings to the public for updates depending on the agenda.
- On another topic, DHSP began partnering several months ago with the California Office of AIDS (OA) on the Home Test Kit Program. DHSP was ensuring kits were distributed to caller ID hotspots countywide.
- The next Regional Learning Collaborative will focus on representatives from OA and various counties, including Ms. Tolentino from LAC, discuss proposed EHE activities on 9/30/2020. The virtual meeting will be hosted by the Center for HIV Identification, Prevention and Treatment Services (CHIPTS).
- ➲ Ms. Tolentino was working with Ms. Barrit and the PACE team on a Spanish-language EHE Initiative presentation.
- ➲ Ms. Tolentino reiterated EHE independent input was welcome in addition to the Commission's collected comments.

8. STANDING COMMITTEE REPORTS

A. Operations Committee

(1) Assessment of the Administrative Mechanism (AAM) Supplemental Report

- Mr. King, Next-Level Consulting, Inc., noted the AAM is a Health Resources and Services Administration (HRSA) requirement. It assesses the speed and efficiency of Ryan White funding allocation and dispersal in jurisdictions.
- LAC's last full AAM was done in 2018. Interviews were conducted with: 24 Planning, Priorities and Allocations (PP&A) and Executive Committee Members; 17 DHSP and DPH staff; and a sample of 16 DHSP-contracted agencies. One resulting recommendation was to do a supplemental assessment that was more inclusive of Commission Members and Alternates and included additional key informant interviews of agencies not interviewed previously.
- Mr. King was contracted for the project. He adapted the original survey and key informant questions in collaboration with the Operations Committee and Commission staff. Mr. King reviewed findings from the Report which was in the packet and is available on the Commission's website.
- A Survey Monkey survey went to all the then 47 Commission Members and Alternates and 30 (64%) responded.
- Key informant interviews were held with 15 people representing a random sample of 10 contracted agencies not interviewed before and selected to reflect a range of services provided and numbers of contracts with DHSP.
- Mr. Pérez thanked Mr. King for the helpful feedback. He asked if any DHSP staff were interviewed as part of the supplement and what suggested next steps might be. Mr. King replied the supplement was focused on expanding Commissioner and agency representation so no additional DHSP staff were interviewed. Regarding next steps, the findings have been shared with the Operations Committee and now the Executive Committee. He felt next steps and recommendations might be developed collectively and in light of the findings of the original AAM.
- Mr. Green reported Operations recommended forming a small AAM Work Group to review findings and draft next steps. Ms. Barrit added Operations reviewed recommendations after the initial AAM with Michael Green, PhD, MHSA to identify what was feasible and, if feasible, whether it should be a short-, medium-, or long-term goal. She supported the AAM Work Group to draft the initial recommendations.
- Mr. Pérez noted this Report reflects a pre-COVID-19 point in time. Improving reported issues like consistency and responsiveness since 2019 has been hard in the COVID-19 era with 80% of the DHSP work force deployed as DSWs. He felt the best way to improve inconsistency was to have consistent program manager leaders. He will be reviewing the Report closely with Paulina Zamudio who leads the Contracting Services Section.
- Regarding the very high staff turnover, Mr. Pérez acknowledged the difficulty that causes in managing the work force. It is, however, well known and acknowledged by DPH that DHSP is its key recruiting ground. DHSP staff standards, expectations, training, and work ethic that are part of the DHSP response to HIV and STDs develop skills that other parts of DPH find very attractive. Unfortunately, turnover is expected to continue unabated.
- ➲ Mr. King was able to upload PowerPoint slides to WebEx that will also be provided to staff for distribution.
- ➲ Individuals interested in joining the AAM Work Group may contact staff.

(2) Membership Management

- Mr. Green reported Kevin Donnelly's application as an UC will be moving forward shortly.
- Two additional UCs, Damontae Hack and John Blackman, have also been interviewed. Mr. Blackman was referred by Mr. Preciado and interviewed well, but has not yet attended any meetings so his application was paused until he can do so, become more familiar with the Commission, and demonstrate his commitment.
- While two UCs were pending interviews, Operations continues to recruit for openings including openings for UCs.

- Operations did follow-up on last month's Youth/Young Adult discussions. Each Committee Member was asked to attend a Consumer Advisory Board (CAB) meeting to promote the Commission. Staff were also asked to create website promotional material that can be downloaded for use in, e.g., newsletters and agency calendars.

(i) New Member Application

- _Everardo Alvizo_ Ms. Campbell and Ms. Gordon were on the interview panel. Ms. Gordon commented he interviewed well, was knowledgeable, had a good understanding of the HIV community, and had contacts with some of the key populations that the Commission needs to attract to participate at the table.
- Ms. McClendon noted a recent issue that shifts some demographic information when converting applications to PDFs. Mr. Alvizo's corrected race/ethnicity is Hispanic and his corrected age is 30-39.

MOTION #3: Approve New Member Applicant, Everardo Alvizo, for the City of Long Beach Representative seat and elevate to the full Commission on HIV Meeting of 10/8/2020 for approval, as presented ***(Passed: Yes -*** Cataldo, Davies, Green, Nelson, Pérez, Gordon***; No -*** none***; Abstentions -*** none***)***.

(3) Mentorship Program Implementation

- Volunteers to serve as mentors to date are: Alasdair Burton, Frankie Darling-Palacios, Ms. Nelson, and Messrs. Preciado and Green. These will be sufficient for our current new members.
- ➲ Mr. Green will be reaching out for more Commissioners to volunteer to meet the need as new people join.

(4) 2020 Training Schedule: The Co-Chairs will facilitate the next training on 10/1/2020, at 10:00 am, on Orientation.

B. Planning, Priorities, and Allocations (PP&A) Committee

(1) Program Directives for Maximizing Ryan White Part A and Minority AIDS Initiative (MAI) Funds for Program Years (PYs) 30, 31, 32

- Ms. Cataldo reviewed the Program Directives document in the packet. Directives provide DHSP guidance on service models or strategies, population priorities, and methods for overcoming barriers to care.
- Ms. Barrit noted revisions, as follows:
  - ⇨ Page 2: Updated to reflect 2019 HIV Surveillance Report.
  - ⇨ Page 4, Item 3: Add "and older adults." Refer to Aging Task Force for further guidance on age parameters.
  - ⇨ Page 4, Item 4: Add "to include dietary guidance" to line 1 and "(to include feminine hygiene items)," to line 5.
  - ⇨ Page 4, Item 5: Clarify language and revise phrase on number of clients from specific number pertaining to Housing for Health (HFH) to "increase target number of clients during the reallocation process." The change is less specific on items related to contracting while reminding PP&A about allocation needs.
  - ⇨ Page 4, Item 6: Shorten overall and delete section on Uber and Lyft already addressed with DHSP contracts.
  - ⇨ Page 5: Standards status was updated as appropriate.
- Mr. Pérez affirmed that DHSP was receptive of the Directives from the Commission. He had not had the chance to read them, however, so would abstain on the vote.
- Mr. Green noted the aging population is half of the epidemic yet not well reflected in these Directives. The topic has been referred, as noted earlier, to the Aging Task Force and he looks forward to its recommendations.

MOTION #4A: Extend meeting 20 minutes ***(Passed by Consensus)***.

MOTION #4: Approve Program Directives for Maximizing Ryan White Part A and MAI Funds for PYs 30, 31, and 32, as presented ***(Passed: Yes -*** Cataldo, Green, Nelson, Gordon***; No -*** none***; Abstentions -*** Pérez***)***.

C. Standards and Best Practices (SBP) Committee

(1) Child Care Standards of Care (SOC) - UPDATE

- ➲ SBP invited comments from the Executive Committee on this SOC.

(2) Universal SOC – UPDATE: Ms. Barrit was creating a draft SOC for SBP review at its next meeting.

D. Public Policy Committee

- Ms. Nelson reported the House passed a Continuing Resolution (CR) that would fund the federal government through 12/11/2020. The Senate and President Donald Trump would need to sign it by 9/30/2020 to avoid a shutdown.
- It was likely to be signed, but does not include any COVID-19 relief.
- The impact of efforts to fill Justice Ruth Bader Ginsburg's seat is unknown at this point. One case coming forward on 11/10/2020 is California v. Texas regarding the Affordable Care Act and its dependency on the individual mandate.
- On 9/23/2020, Governor Newsom extended the Executive Order moratorium on evictions through 3/31/2020. Ms. Nelson was unsure how that will interact with AB 3088, signed 9/1/2020, that also extended eviction protections.

- The End the Epidemics (ETE) Racial Justice Working Group released a statement on 9/22/2020 in the packet. Mr. Green and Ms. Campbell supported signing on to the statement.
- ➲ Agendize ETE Racial Justice Working Group statement for endorsement at the next Commission meeting.

(1) **2020-2021 Legislative Docket – UPDATE**: Ms. Nelson reported 9 of 24 bills on the Docket have reached Governor Gavin Newsom's desk He has until 9/20/2020 to sign them, veto them, or do neither. Unsigned bills pass into law.

(2) **Ballot Initiatives**: The Public Policy Committee took initial initiative positions at its September meeting. Positions will be reviewed over the next two meetings.

(3) **Fiscal Year (FY) 2020-2021 Measure H and Homeless Housing, Assistance, and Prevention (HHAP) Funding Recommendations**: LAC released a long memorandum reporting on the allocation of funds.

(4) **STD Epidemic – UPDATE**: A proposed federal plan addresses the STD epidemic in the United States. Ms. Nelson urged everyone to read and comment on the plan and how it might work in conjunction with EHE.

(5) **Housing Saves Lives: United States Department of Housing and Urban Development (HUD) Rule Change Serving Transgender Persons**: Ms. Nelson noted the Committee's public comment in the packet. It was submitted with Commission Co-Chair approval to oppose the HUD proposed rule change that would allow shelters to disregard an individual's gender identity in housing.

9. CAUCUS, TASK FORCE, AND WORK GROUP REPORTS

A. Aging Task Force - 9/28/2020, 10:00 am - 12:00 noon
- Ms. Barrit reported the next meeting will be focused on data to inform recommendations requested by PP&A.
- Ms. Campbell called attention to the perinatal population which is also often under-addressed.

B. Black/African American Community (BAAC) Task Force - 9/28/2020, 1:00 - 3:00 pm
- Ms. Campbell, Co-Chair, met with the Commission and Public Policy Co-Chairs to discuss dissemination of the BAAC recommendations across the various Commission bodies to inform their work.
- ➲ Refer development of a racial justice statement regarding Breonna Taylor to BAAC Task force. The statement can build on the solidarity statement released in May 2020.

C. Consumer Caucus - 10/8/2020, 3:00 - 5:00 pm
- Ms. Barrit reported DHSP was currently looking for a new Language Services contractor. This is an important supportive service that helps maintain engagement in care. Ms. Zamudio will facilitate a focus group on service needs.
- Staff will also provide more training requested by the Caucus in how to read financial reports in order to improve understanding of the Priority Setting and Resource Allocation (PSRA) decision-making process.
- ➲ Staff will promote the Language Services focus group. Staff will also work with Ms. Zamudio to provide space for a non-English-speaking focus group as well.

D. Women's Caucus - 10/19/2020, 2:00 - 4:00 pm
- The next Lunch & Learn Women & HIV series segment will be Addressing Economic & Housing Insecurity on 10/14/2020, 12:00 noon to 1:30 pm. Average attendance has been about 40, but can reach 50-80.
- Mr. Donnelly added that barriers to participation were discussed at the last meeting.

E. Transgender Caucus - 10/27/2020, 10:00 am - 12:00 noon: Public Policy Co-Chairs Nelson and Kochems joined the last meeting to discuss policy issues of concern to the transgender community. Ms. Nelson felt it went well. The Committee will follow up on a couple of questions and fruitful dialogue has begun. Work is done well when communication lines are open.

<u>V. NEXT STEPS</u>

10. TASK/ASSIGNMENTS RECAP: There were no additional items.

11. AGENDA DEVELOPMENT FOR NEXT MEETING: There were no additional items.

<u>VI. ANNOUNCEMENTS</u>

12. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS: There were no announcements.

<u>VII. ADJOURNMENT</u>

13. ADJOURNMENT: The meeting adjourned at 3:30 pm.

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Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

EXECUTIVE COMMITTEE MEETING MINUTES

October 22, 2020

MEMBERS PRESENT	MEMBERS PRESENT *(cont.)*	PUBLIC	COMM STAFF/ CONSULTANTS
Al Ballesteros, MBA, *Co-Chair*	Katja Nelson, MPP	Carlos Moreno	Cheryl Barrit, MPIA
Bridget Gordon, *Co-Chair*	Mario Pérez, MPH	LCDR Jose Antonio Ortiz, MPH	Carolyn Echols-Watson, MPA
Raquel Cataldo	Juan Preciado	Greg Wilson	Dawn McClendon
Michele Daniels	Justin Valero, MA		Jane Nachazel
Erika Davies		**DHSP STAFF**	Sonja Wright, MS, Lac
Joseph Green	**MEMBERS ABSENT**	Julie Tolentino, MPH	
Lee Kochems, MA	Kevin Stalter		

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.

CONTENTS OF COMMITTEE PACKET

1) **Cover Page**: Executive Committee Virtual Meeting, *10/22/2020*
2) **Agenda**: Executive Committee Meeting Agenda, *10/22/2020*
3) **Code**: Code of Conduct, *4/11/2019*
4) **Statement**: To End HIV, We Must End Racism, *2020*
5) **Flyer**: Virtual Lunch & Learn Series: Share, Learn, and Sustain Our HIV Movement; Women + HIV, A Special 4-Part Conversation; November 10, 2020, 12:00-1:30 pm, Women + HIV: The Impact of Trauma; *2020*
6) **Memorandum**: Comments on Ending the HIV Epidemic (EHE) Draft Plan, *10/16/2020*
7) **Recommendations**: (REVISED) Black/African American Community (BAAC) Task Force Recommendations, *10/10/2019*
8) **Table**: Continuing the Commitment to Ending HIV, Once and For All; 2020 Virtual Annual Meeting Agenda; November 12, 2019; 9:00 am-1:15 pm; *TENTATIVE/DRAFT 10/22/2020*
9) **Duty Statement**: Committee Co-Chair, *Approved 3/28/2017*
10) **Roster**: 2020 Membership Roster, *Updated 10/2/2020*
11) **Membership Application**: Damontae Hack, *8/27/2020*
12) **Flyer**: Virtual Training Schedule for Commissioners and Community Members, *8/2020*
13) **Flyer**: Planning CHATT, Setting the Standard: A Comprehensive Overview of Service Standards for Part A Planning Councils/Planning Bodies Webinar, *10/22/2020*
14) **Memorandum**: Request for Information Developing an STI Federal Action Plan, *6/3/2019*
15) **Feedback**: STD Strategic Plan Draft: Public Comment Feedback from Los Angeles County DPH, *10/16/2020*

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST: Ms. Gordon called the meeting to order at 1:05 pm.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

MOTION #1: Approve the Agenda Order, as presented ***(Passed by Consensus)***.

2. **APPROVAL OF MEETING MINUTES**
MOTION #2: Approve the Executive Committee Meeting Minutes, as presented ***(Postponed)***.

II. PUBLIC COMMENT

3. **OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION**: There were no comments.

III. COMMITTEE NEW BUSINESS ITEMS

4. **OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA**: There were no items.

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**

A. Commission/County Operational Updates
- Ms. Barrit welcomed Ms. Wright back from her Disaster Services Worker (DSW) deployment as a COVID contact tracer.
- All Commission Members should have received emails from the Board of Supervisors (Board) and Commission staff about having their pictures taken for new badges. Staff appreciate Members going in to the Hall of Administration for a photo session on the dates noted. Contact Commission staff for assistance, if needed.
- Commission staff were working with Mr. Pérez and his team to spread the Commission's Operational Budget across grants to support Ending the HIV Epidemic (EHE) efforts and continuing to meet its local Planning Council (PC) charge.

B. Virtual Lunch & Learn Series
- Ms. Barrit reported the series has been going very well. The next segment will be part of the Women + HIV series, The Impact of Trauma, on 11/10/2020, 12:00 noon to 1:30 pm. Guest speakers will be Susie Baldwin, MD, MPH and Niccole Perras, MPH, LMFT of the Office of Women's Health, Los Angeles County (LAC) Department of Public Health (DPH). The Women's Caucus Co-Chairs Shary Alonzo and LaShonda Spencer, MD will again facilitate.
- The Lunch & Learn Series includes consumer panels and testimonies which offer great insights as well. All are welcome.

C. Ending the HIV Epidemic (EHE) and Commission Activities
- Ms. Barrit thanked everyone who offered input on the EHE Plan. The memorandum in the packet summarizes comments from the 10/8/2020 Commission on HV Meeting, other comments submitted, and staff analysis.
- As a living document, the conversation to refine and strengthen the EHE Plan is expected to continue and staff will continue to coordinate work with Ms. Tolentino to move towards the shared vision of ending HIV equitably for all.
- Announcements have gone out for the EHE meeting in Spanish on 10/28/2020, 2:00 to 3:00 pm. The Consumer Caucus had urged outreach to ensure broad feedback from the Spanish-speaking community. The meeting will be hosted by the Commission, DHSP, and the Prevention through Active Community Engagement (PACE) team. All are welcome.
- Ms. Barrit will work with Ms. Tolentino on a slide set for Commissioner presentations once the EHE Plan is submitted.

D. 11/12/2020 Annual Meeting Preparation
- Ms. Barrit reported common themes in feedback on the Annual Meeting were: sustain EHE Plan conversations on federal, regional, and local activities; ensure HIV movement and planning efforts are inclusive and intergenerational.
- Separate from the Annual Meeting, there was also interest in tracking work on the ongoing health agency integration.
- Ms. Barrit noted the draft agenda in the packet starting with the usual welcome, meeting review, and recognition of outgoing Commission Co-Chair Al Ballesteros.
- Harold Phillips, Senior HIV Advisor and Chief Operating Officer, EHE: A Plan for America, has confirmed he will speak on 2021 expectations. Ms. Barrit asked the PACE team if he might be available, they invited him, and he promptly agreed. It is always helpful to foster dialogue with our federal partners. Mr. Phillips has indicated he looks forward to the opportunity to learn about what is happening in LAC and how he might help.
- Mr. Pérez is also confirmed to represent DHSP though the topic has yet to be determined.
- Either Naina Khanna, Executive Director, or Venita Ray, Deputy Director, Positive Women's Network, will come to support the effort to develop a more inclusive and intergenerational HIV movement.
- A community speak out will offer the opportunity for Commissioners to hear testimony from the community, perhaps facilitated by the Consumer Caucus Co-Chairs Felipe Gonzalez and Carlos Moreno.

- ➲ Feedback was requested in the next few days so the agenda can be finalized and a promotional flyer developed.

6. CO-CHAIR REPORT

A. Congratulations to Executive At Large Member Justin Valero, MA and 2021 Commission Co-Chair David Lee, MPH, LCSW

B. Holiday Meeting Schedule for November and December 2020
- Ms. McClendon noted the regularly scheduled meetings would fall on Thanksgiving and Christmas Eve respectively. The Operations Committee has chosen to hold one joint meeting. A poll was out to choose a date.
- Potential matters for Executive to address could include member applications, Standards of Care (SOC), re-allocations, and any Annual Meeting follow-up.
- ➲ Agreed to hold one November/December Executive Committee Meeting aligned on the same day as the Operations Committee Meeting as usual. The Operations meeting date poll will be revised and resent to both committees.

C. 10/8/2020 Commission Meeting Feedback: There was no feedback**.**

D. Board Letter Regarding Contractual Process - UPDATE
- Mr. Ballesteros noted he, Ms. Gordon, and Ms. Barrit have had calls with all the Board Offices. Updates have been provided and questions answered, but there has been no discernable movement as yet.
- Ms. Barrit added the check-in calls with Mr. Pérez and Jeffrey Gunzenhauser, MD, MPH have also been helpful in moving items such as the Request for Proposals (RFP) for community engagement. The next call will be 10/30/2020.

E. 2021 Committee Open Nomination + Elections Preparation: Ms. Barrit reported all Committees have agendized nominating their Co-Chairs for 2021. She noted PP&A still has just one Co-Chair.

F. At Large Executive Committee Member Open Nominations - REMINDER + ONGOING: Ms. Gordon noted one At Large seat remains open. Full Commissioners of at least one year are eligible.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT

A. Fiscal, Programmatic, and Procurement Updates
- Mr. Pérez reported DHSP has received the Commission's Program Directives. He will have a conversation with his team to identify an internal process to assign ownership to items who will address them and report back.
- He recommended a conversation with the Commission to discuss the Black African American Community (BAAC) Task Force recommendations. Some were also incorporated into the Program Directives. He suggested prioritizing the recommendations by which might be moved quickly and which will require more work. He suggested creating an ongoing communication and feedback loop around all the pieces would be very important.
- DHSP has submitted its Ryan White HIV/AIDS Program (RWHAP) Part A application. He thanked all for their feedback. There were still a few Conditions of Award (COA) that needed to be completed.
- The Commission Operational Budget for this and next year were being reviewed. The goal is to have at least a framework of the Commission budget in place before the start of the Commission's Fiscal Year (FY) on March 1st.
- DHSP was not quite ready to present Part A projections in light of COVID-19 billing and invoicing delays. The hope was to provide an expenditure report in November although projections may still be a little soft.
- It may be necessary to shift allocations as late as January 2021 as expenditure data becomes available. Depending on circumstances, the Executive Committee may need to approve adjustments on the Commission's behalf. For example, if Part A is underspent, Minority AIDS Initiative (MAI) expenditures might be moved to Part A to maximize that grant. Part A funds must be used in the grant term while unspent MAI funds may be carried over one year.
- DHSP was eager to offer Child Care SOC feedback, but would wait to incorporate feedback from three focus groups.
- Increased attention to drug user health in LAC continues. The Centers for Disease Control and Prevention (CDC) alerted people to an HIV outbreak among injectors. A recent article also discussed fentanyl-related deaths among substance users, especially on the West Coast. He urged discussions on the services and how they might be more comprehensive.

B. Ending the HIV Epidemic (EHE) Activities + Updates
- Ms. Tolentino reiterated the earlier request to publicize the Spanish-speaking event very broadly.
- General public comment closed on 10/16/2020, but additional voices will be heard from next week's Spanish-speaking group as well as time for the EHE Steering Committee to provide feedback in a smaller group discussion.
- There have been 26 public comments received. They were being reviewed for inclusion in the EHE Plan.

- DHSP was also working with the Health Education/Risk Reduction (HE/RR) and the Vulnerable Populations contracts to include activities in their Scopes of Work (SOW) that are specific to EHE.
- The Connect2Protect (C2P) Coalition asked Ms. Tolentino to present at its 9/25/202o meeting on how to get involved.

8. STANDING COMMITTEE REPORTS

A. Operations Committee

(1) Membership Management:

(i) New Member Applicant Interviews: Interviews were ongoing. As of 10/2/2020, there were 14 vacancies.

(ii) New Member Application – Damontae Hack: Mr. Preciado noted Mr. Hack interviewed very well.

MOTION #3: Approve New Member Applicant, Damontae Hack and elevate to the full Commission on HIV Meeting of 11/12/2020 for approval, as presented ***(Passed: Yes -*** Cataldo, Daniels, Davies, Green, Kochems, Nelson, Pérez, Preciado, Valero, Gordon, Ballesteros***; No -*** none***; Abstentions -*** none***)***.

(iii) Seat Change to Representative Board Office 2 - Danielle Campbell, MPH

- Ms. Campbell previously sat on the HIV Stakeholder #5 seat, but the Board appointed her to the Representative Board Office 2 seat at its last meeting. She had expressed interest in the seat.
- When there is a change in elected officials, the Commission welcomes the new person, provides them with an overview of the Commission, and introduces their Office's Commission representative. It has never been the case that a new Supervisor dismissed any existing Commission representative.

(ii) Change to Membership – Stephanie Cipres, MPH

- Ms. Cipres has left the Maternal, Child, and Adult/Adolescent (MCA) Center so is no longer eligible for the Part D Representative seat. She will not be eligible for any full Commission seat in her new position.
- Ms. Barrit said she now works for DPH. She may occupy a Committee Only seat if her employer approves.

(2) Youth/Young Adult Engagement and Outreach Strategies

- Mr. Preciado urged all Commissioners to attend Consumer Advisory Board (CAB) and other community meetings to familiarize members with the Commission. Material is available that can be modified for presentations.

(3) Peer Collaborator/Buddy Program aka Mentorship Program Implementation: Partnerships will be done 11/19/2020.

(4) 2020 Training Schedule - REMINDER: The Training Schedule was in the packet. The next will be 10/29/2020, 10:00 to 11:30 am, on the Priority Setting and Resource Allocation (PSRA) process. The last two will be 11/5/2020 on Service Standards Development and 11/19/2020 on Policy Priorities and the Legislative Docket.

B. Planning, Priorities, and Allocations (PP&A) Committee

- Ms. Cataldo noted the last meeting discussed expenditure and re-allocation issues addressed earlier by Mr. Pérez.
- It was also noted that, following provider requests, funding was now available for durable medical equipment like blood pressure monitors for clients to use at home. DHSP sent out a Dear Colleague letter, but funds were underused.
- PP&A heard an excellent presentation on the Consolidated Plan for the United States Department of Housing and Urban Development (HUD) which includes Housing Opportunities for Persons With AIDS (HOPWA). The City of Los Angeles Housing and Community Investment Department (HCID) has information on its site and public comment remains open. Materials from the presentation are also in the packet on the Commission's website.
- Everyone is invited to join the aforementioned 10/29/2020 PSRA training which will offer an overview of the process.
- ➲ Nominations for Co-Chair remain open. Ms. Barrit will follow-up on whether the one-year eligibility requirement can be met by service in a prior Commission term. She will also check to see if an individual in that situation was interested.

C. Standards and Best Practices (SBP) Committee

(1) Child Care Standards of Care (SOC) - UPDATE: Ms. Davies said this work was paused for DHSP focus group feedback.

(2) Universal SOC - UPDATE: MsDiscussion on this SOC was robust at the last meeting. Telehealth information was being included and lived experience highlighted for staff requirements. Michael Green, PhD, MHSA has also taken it back to DHSP for review and feedback.

D. Public Policy Committee

- Ms. Nelson reported federal news included a debate that evening, but no news on a COVID-19 relief bill. The House passed an updated HEROES Act with $100 million more for Ryan White, but the Senate was not likely to take it up.

- The Department of Homeland Security has proposed a rule which would make it harder for someone to sponsor immigrants due to a new affidavit for a sponsor to assume financial responsibility. She was unsure if the Board had taken a position. The public comment period was still open.
- Multiple medical and other partners filed a petition to the Supreme Court of the United States (SCOTUS) to try to strike down a new Title 10 rule limiting comprehensive reproductive health services. SCOTUS has not yet decided to take it.
- Ms. Nelson and Mr. Kochems will present an overview of Public Policy Committee work to the BAAC Task Force on 10/26/2020. They will discuss BAAC recommendations and collaborative opportunities.
- Richard Zaldivar, Founder and Executive Director, The Wall Las Memorias, will present at the 11/2/2020 Public Policy Committee Meeting. He will provide an update on the The Wall's roundtables on methamphetamine in LAC.
- The CDC revised COVID-19 risk information from 15 minutes consecutive exposure to 15 minutes over 24 hours.

(1) 2020-2021 Legislative Docket - UPDATE: Ms. Nelson noted bills from this session were reviewed at the 10/8/2020 Commission Meeting. The next term's Docket has not begun to be developed as yet.

(2) Ballot Initiatives: Initiatives were also discussed at the 10/8/2020 Commission Meeting. Everyone was urged to vote.

(3) Housing Opportunities for Persons with AIDS (HOPWA) Request for Proposal (RFP): The HOPWA RFP was out to bid. An amendment to language was released 10/16/2020 in response to community feedback at the bidders' conference. The prior language would have disallowed current subcontractor arrangements which can be valuable.

9. CAUCUS, TASK FORCE, AND WORK GROUP REPORTS

A. Aging Task Force - 10/26/2020, 9:00 am - 1:00 pm: There was no additional discussion.

B. Black/African American Community (BAAC) Task Force - 10/26/2020, 1:00 - 3:00 pm

- Mr. Wilson, Co-Chair, looked forward to working to increase collaboration with the Public Policy Co-Chairs. The Task Force felt that collaboration can be a model for other bodies.
- The Task Force developed a collective statement and was solidifying membership standards to facilitate recruitment.

C. Consumer Caucus - 10/8/2020, 3:00 - 5:00 pm

- Ms. Barrit said the Caucus reviewed FY 29 Expenditures Report to practice working with data used for the PSRA.
- Paulina Zamudio also joined the meeting to collect input on Language Services. Later, the meeting restarted in Spanish to collect more Language Services input, but people did not attend. Another time was being developed for that input.

D. Women's Caucus - 11/16/2020, 2:00 - 4:00 pm

- The next Lunch & Learn, Women & HIV: The Impact of Trauma will be 11/10/2020, 12:00 noon to 1:30 pm.
- The Caucus has elected to meet every other month going forward.

E. Transgender Caucus - 10/27/2020, 10:00 am - 12:00 noon: There was no additional discussion.

V. NEXT STEPS

10. TASK/ASSIGNMENTS RECAP: There were no additional items.

11. AGENDA DEVELOPMENT FOR NEXT MEETING:

➲ Agendize discussion of new federal STD Strategic Plan and the DHSP comments included in the packet for early review.

VI. ANNOUNCEMENTS

12. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS: There were no additional items.

VII. ADJOURNMENT

13. ADJOURNMENT: The meeting adjourned at 2:19 pm.

HIV Planning Body Assessment Guide

A Resource for HIV Planning

October 2020

Developed by HealthHIV on behalf of the Integrated HIV/AIDS Planning Technical Assistance Center (IHAP TAC)

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Overview of Resource

The **Integrated HIV/AIDS Planning Technical Assistance Center (IHAP TAC)** developed an assessment guide to help jurisdictions review and evaluate the effectiveness of the structure, policies and procedures, membership, and stakeholder/consumer engagement of HIV prevention and care planning bodies, including integrated HIV planning groups. “Effectiveness” is defined by how well the planning body’s structure, policies and procedures, consumer engagement and implementation supports its ability to carry out its mission and objectives. Through the comprehensive assessment, HIV planning bodies are able to identify areas for improvement in order to support the development of effective and efficient planning processes. The assessment process includes three phases, which are described in the sections that follow:

- Engagement
- Assessment
- Recommendations

Historically, people with HIV have used the phrase “nothing about us without us” to ensure a voice at the table for planning activities to address HIV/AIDS in their communities. HRSA/HAB has embraced this by requiring the participation of people with HIV in RWHAP Part A Planning Councils. It is important that this assessment include the voices of people with HIV.

Logistics and Responsibilities

The mixed-method assessment involves collecting and analyzing quantitative (online survey) and qualitative (key informant interviews [KIIs]) data from **key stakeholders** involved in the HIV planning process in a jurisdiction. The assessment should engage all HIV planning body members and also may include other key stakeholders such as non-voting, ex-officio, former members, state/local government representatives, etc.

HIV planning body leadership should facilitate the engagement of, and communication with, HIV planning body members and external stakeholders throughout the assessment process, which will culminate in a discussion of assessment findings and the development of recommendations and next steps.

Ideally, an unbiased third-party representative will administer the assessment tools and maintain the confidentiality of all assessment participants. The survey can be implemented via a web-based survey tool (e.g. SurveyMonkey) and the KII tool is designed to be implemented by phone, over video conferencing or in-person. All responses should be reported in aggregate to protect confidentiality of individual HIV planning group members.

Goal and Objectives

The goal of the assessment process is to review and enhance the HIV planning body’s ability to carry out its mission by identifying key strengths and areas for improvement related to the

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effectiveness of its operating structure, policies and procedures, membership, and stakeholder/consumer engagement. The key objectives to be achieved are:

- Conducting a mixed-method assessment of HIV planning group structure, policies/procedures, membership, and engagement;
- Reviewing the identified areas for improvement, key recommendations, and model practices that may be implemented; and,
- Presenting summarized data and its implications to HIV planning body members to determine priority areas, next steps, and adaptation and/or implementation of recommendations.

Recommended Timeline

The following chart outlines a timeline for the implementation of the assessment process spanning approximately 12-16 weeks.

HIV Planning Body Assessment Steps and Anticipated Timeline			
	Key Step	**Responsible Party**	**Timeline**
Phase 1 Engagement	Conduct kick-off call with planning leadership and key stakeholders to outline objectives and intended outcomes	Assessment lead and HIV planning body leadership	Weeks 1-2
	Review planning body's written documentation (orientation, bylaws, membership information)	Assessment lead	Weeks 2-3
	Identify a minimum of six contacts for key informant interviews (KIIs) and provide contact information	HIV planning body leadership	Weeks 2-3
Phase 2 Assessment	Adapt online survey and interview guide based on introductory call and written documentation	Assessment lead	Weeks 2-3
	Review and approve online survey and interview guide for implementation	HIV planning body leadership	Weeks 4-5
	Propose communication plan and strategies to engage and gain buy-in for assessment process	Assessment lead	Weeks 4-5
	Distribute anonymous online survey (via planning body listserv) and field for two-three weeks	Assessment lead	Weeks 6-8
	Conduct four to six 60-minute KIIs	Assessment lead	Weeks 6-8
	Analyze and summarize online survey results and KII data	Assessment lead	Weeks 8-10
Phase 3	Facilitate conference call to review initial findings with key stakeholders and leadership	Assessment lead and HIV planning body leadership	Week 11

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Recommendation	Finalize assessment report with recommended areas for improvement	Assessment lead	Weeks 12-13
	Lead discussion (half-day, approx. 4 hours) with HIV planning body to present findings and facilitate identification/ prioritization of next steps for improvement	Assessment lead	Weeks 12-16
	Identify next steps for follow-up technical assistance and/or training	Assessment lead	Post training

Phase 1. Engagement and Information Gathering

If a third-party is implementing the assessment, it is essential for that individual or agency to have a comprehensive understanding of the HIV planning body and its culture, membership, and environment. The engagement and information gathering phase of the assessment process should include conversations with HIV planning body leadership to outline the objectives and intended outcomes of the assessment; list documentation requests; gain clarification on planning body structure, policies, and procedures; and ensure full cooperation and clear communication with HIV planning body members regarding the assessment activity.

Background documentation may include:

- Acronym guide/glossary of terms
- Executive Board and committee lists
- Conference and workshop attendance
- Confidentiality contract
- Conflict of interest disclosure form
- Meeting protocols, including minutes
- Membership application form
- Member contact information
- Membership years of service
- Planning body bylaws orientation and mentorship (includes list of orientation materials)
- Outreach events/activity form
- Taskforce/ad hoc meeting summary
- Timetable of tasks

Phase 2. Assessment

The planning body assessment is conducted through an online survey and individual key informant interviews (KIIs). The HIV planning body will implement the two assessment modalities concurrently: an anonymous online survey of the full planning body membership and phone interviews with a diverse group of six HIV planning stakeholders, including voting and non-voting members, government representatives, and facilitators/contractors.

Member/Stakeholder Survey

The purpose of the online survey is to provide the planning body with information for reflection, discussion, planning, and development to improve the group's practices, structure, and community engagement efforts. The anonymous survey data may show where planning members are in consensus, disagreement, or there are significant outliers. Survey participants are asked to provide thorough, thoughtful, and truthful answers. All answers to the survey must remain anonymous and be reported in aggregate to protect the confidentiality of respondents.

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The survey instrument includes 29 adaptable closed- and open-ended questions related to: membership demographics and skills; planning body structure; the planning body's recruitment and orientation activities; relationship with external stakeholders; and key successes and areas for improvement.

Key Informant Interviews

KIIs will further the participation and voice of the planning body's members in the assessment process. A diverse group of at least six members, including at least one person with HIV, should be asked to participate. A diverse set of perspectives may include both new and seasoned members, both government and community representatives, consumers, representatives of focus populations, process-leaders within the planning group or committee leads, planning body contractors, or planning meeting facilitators. The qualitative information from KIIs must be de-identified and aggregated for the reporting process. The KII tool consists of 28 adaptable, open-ended questions, which can be completed within 60 minutes, and includes discussion of member background, current engagement and role within the planning group, the purpose of the planning group and ability to fulfill its role, group membership, and future aspirations/anticipated challenges.

Phase 3. Recommendations

Data from the anonymous survey and KIIs are summarized and reported in aggregate, highlighting key findings and areas for consideration/discussion. While the assessment aims to identify areas for improvement, it also is important to highlight the successes and effectiveness of the planning body and its HIV planning efforts. When the survey demonstrates consensus or disagreement among members in areas related to planning body effectiveness, the KIIs should be able to provide the context and details to clarify or contextualize survey responses. For example, the survey may indicate that 90% of members believe the new member orientation process is "effective" and 10% (two members) believe the process is "ineffective." Not only would it be important to gain context for this disagreement in the KIIs, but it also should be a point of discussion when the data are presented to the membership. Why do two members disagree strongly with others? Are they simply outliers or is there a communication or process issue?

Some areas for improvement may focus on planning body structure, membership engagement and/or recruitment, community/consumer engagement, and monitoring and tracking activities. By examining the areas of improvement, a planning body will be able to engage in a discussion including specific strategies or recommendations to address improvements.

Ultimately, the assessment and subsequent discussion among HIV planning body members will lead to a better understanding of how to ensure and improve the planning body's effectiveness in supporting state and local ending the HIV epidemic planning.

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Appendix 1. Survey Guide

The following survey is part of a mixed-methods assessment of your current HIV planning practices, structure, and stakeholder engagement efforts. This process will help your planning body better understand how to ensure and improve its effectiveness and role in ending the HIV epidemic.

The below Survey guide and Key Informant Interview guide are meant to serve as a template; any questions can be added or removed based on site preference, and both tools will be edited and adapted to align with site needs.

Participation and transparency in this assessment process is essential. The anonymous, online survey will collect your feedback, which will be de-identified and reported in aggregate to ensure confidentiality of all respondents.

Member Information

1. Please indicate if you identify with any of the following demographic characteristics or groups (Check all that apply.)

- Person with HIV
- Person with viral hepatitis
- Person who injects or formerly injected drugs
- Heterosexual woman
- Heterosexual man
- Gay, bisexual, or same-gender-loving man
- Lesbian or bisexual woman
- Transgender
- Currently or formerly on PrEP
- Currently or formerly experiencing homelessness
- Person who has engaged in sex work (exchanged sex for money or drugs)
- Born outside the U.S.
- Baby Boomer (born 1945-1965)
- Youth (born 1995-2006)

2. Please indicate your racial identity (Check all that apply.)

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latinx
- Native Hawaiian or Pacific Islander
- White or Caucasian
- Other, please specify: _________________________

3. Please indicate your gender identity (Check all that apply.)

- Female

- Male
- Gender non-conforming or non-binary
- Prefer not to say
- Prefer to self-describe: _______________________

4. Do you identify as transgender?

- Yes, male-to-female
- Yes, female-to-male
- No
- Prefer not to say

5. I am an employee or board member of the following organizations. (Check all that apply)

- AIDS service organization/community-based organization (ASO/CBO) serving priority populations
- Health department (state, local)
- Healthcare organization (e.g. hospital, health center, private practice)
- Other medical service provider
- Mental health/behavioral health provider
- Other government health entity (e.g. state Medicaid)
- Other non-governmental organization serving priority populations (e.g. charity, foundation, advocacy)
- Social service provider
- None of the above
- Other, please specify: ______________________

6. How would you describe the area you primarily live in?

- Urban
- Suburban
- Rural

7. What areas of expertise do you contribute to the [HIV planning body]? (Check all that apply)

	1= no knowledge / skills	2= basic knowledge / skills	3= intermediate knowledge/ skills	4= advanced knowledge/ skills	N/A
Adolescent or youth health					
Aging with HIV					
Behavioral or mental health					
Case management					
Corrections/law enforcement					
Epidemiology and data analysis					
Evaluation					
Faith-based communities					
Federal health policy					
Harm reduction					
Health finance					
Health insurance					
Health planning					

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HIV care and treatment					
Housing and homelessness					
Indigenous/native population health					
LGBTQ+ health					
Outreach/community health					
Partner Services					
PEP (post-exposure prophylaxis)					
PrEP (pre-exposure prophylaxis)					
Primary health care					
Ryan White HIV/AIDS Program					
STI screening and treatment					
Social media and marketing					
Substance use treatment					
Viral hepatitis screening and/or treatment					

8. What other skills, not listed above, such as lived experience, do you bring to the [HIV planning body]?

____

[HIV planning body] Meetings

[Insert name in [HIV planning body] and adapt questions/selections based on existing structure]

Please respond to the following questions with your honest opinion.

9. How many full [HIV planning body] meetings would you like to participate in annually?

- ○ One
- ○ Two
- ○ Three
- ○ Four or more
- o Other, please specify: ____________________________

10. Does each individual [HIV planning body] meeting have set objective(s) that are being met?

- ○ Yes, we have set objectives for each meeting, and they are being met.
- ○ Yes, we have set objectives for each meeting, but they are not being met.
- ○ No, we do not have set objectives for each meeting.
- ○ I don't know.

11. Are meetings run efficiently or is there significant time that could be better utilized?

- ○ Yes, they are run efficiently.
- ○ No, there is a lot of unclaimed time.
- ○ I don't know.

12. Does your participation on the [HIV planning body] help to make an impact on HIV in your community?

- ○ Yes
- ○ No
- ○ I don't know.

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13. <u>While our country faces the COVID-19 pandemic</u>, rank which meeting format you are most willing and able to participate in. (1= most willing/able, 5= least willing/able)

- Online, web meeting <u>with</u> video conferencing
- Online, web meeting without video conferencing
- Conference call
- Other, please specify and rank: ___________________________

14. In an ideal world (post-COVID), rank which meeting format you are most willing and able to participate in. (1= most willing/able, 5= least willing/able)

- In-person, altogether
- In-person, regional meetings
- Online, web meeting with video conferencing
- Online, web meeting without video conferencing
- Conference call
- Other, please specify and rank: ___________________________

15. How satisfied are you with your ability to participate in [HIV planning body] meetings?

- Very dissatisfied
- Somewhat dissatisfied
- Neutral
- Somewhat satisfied
- Very satisfied

-

16. What barriers do you experience related to your participation? (Select all that apply.)

- Feeling as though members do not speak in inclusive ways (not defining acronyms, using overly-technical language, etc.)
- Feeling uncomfortable speaking as someone without seniority.
- Feeling uncomfortable speaking in front of the large group.
- Struggling to find a space in the conversation to speak up.
- Lacking confidence in understanding of how the Planning Body operates (how the planning body fits in with other planning activities in the area, my role in the group, our relationship with government entities, our goals, etc.).
- Feeling that some members condescend others.
- Feeling left out of the loop about planning body activities.
- I do not feel that there are barriers to my participation.
- Other: (please specify other barriers) _________

17. What would you change about the [HIV planning body] meetings? (e.g. format, agenda, culture)

____

<u>[HIV planning body] Policies and Procedures</u>

<u>[Insert name in [HIV planning body] and adapt questions/selections based on existing structure]</u>

Please respond to the following questions with your honest opinion.

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18. How well do the written bylaws, policies and procedures support the [HIV planning body] to achieve mission and objectives?

- Very poorly
- Somewhat poorly
- Neither poorly nor well
- Somewhat well
- Very well

19. How confident are you in <u>your ability</u> to explain the mission and objectives of the planning body to your community?

- Not at all confident
- Not very confident
- Neither confident or not
- Moderately confident
- Very confident

20. Do you feel that the committees effectively support the planning body's mission and objectives?

- Yes
- No
- Unsure

21. How satisfied do you feel with the current structure and function of the [HIV planning body]'s committees?

- Very dissatisfied
- Somewhat dissatisfied
- Neutral
- Somewhat satisfied
- Very satisfied

<u>[HIV planning body] Membership</u>

Please respond to the following questions with your honest opinion.

22. How did you initiate membership/engagement with the [HIV planning body]?

- I was referred/recommended by another planning body member
- I learned about the planning body through my state/jurisdiction's health department website
- I learned about the planning body through an outreach or testing event
- I learned about the planning body in person at the state/jurisdiction/CBO health center
- I learned about the planning body through my clinician or case worker
- I requested information about the planning body because of my personal/professional interests
- Other, please specify: __________________________

23. How long have you been a member of the [HIV planning body]?

____ Years or _____Months

24. How long do you intend to remain a member of the [HIV planning body]? *[Adjust question based term limits that may be listed in the bylaws.]*

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- Planning to end term of service with planning body in less than a year
- 1-2 years
- 3-5 years
- 5-10 years
- 10+ years
- I Don't Know

25. If you are choosing a shorter term of service, why? __________________________________

26. What other planning bodies/groups do you participate on? *[Adjust question based on the HIV planning body being surveyed.]*

- Ryan White Part A Planning Council
- Integrated HIV Prevention & Care Planning Group
- Ending the HIV Epidemic/Getting to Zero/Fast Track Cities planning group
- Viral hepatitis planning
- Other planning group(s), specify: ____________________________
- None of the above

27. Does the planning body as a whole... (Select all that apply)

- Use data to support decisions
- Monitor local and state health department HIV/AIDS activities
- Advocate for self-interests
- Advocate for specific services
- Conduct routine needs assessments
- Evaluate effectiveness of HIV planning activities
- Ensure membership is reflective and inclusive of communities most affected by HIV and viral hepatitis
- None of the above

28. What types of skills or personal/professional experience are missing from the current [HIV planning body] membership? (Select up to three areas)

- Adolescent and youth health
- AIDS service organization operations
- Behavioral health
- Case management
- Corrections/law enforcement
- Aging with HIV
- Epidemiology and data analysis
- Faith-based communities
- Federal health policy
- Financial analysis
- Harm reduction
- Health insurance
- HIV care and treatment
- Outreach/community health
- Housing and homelessness
- Indigenous/native population health
- LGBT health

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- Partner Services
- PEP
- Pharmacology/Pharmacy
- PrEP
- Primary health care
- Program evaluation
- Ryan White HIV/AIDS Program services and funding
- STD screening and treatment
- Social media and marketing
- Strategic planning
- Substance use treatment and services
- Viral hepatitis screening and treatment
- Undetectable = Untransmittable (U=U)
- **Other: _________________**

29. How effective is the [HIV planning body] in recruiting new members that reflect the HIV epidemic and align with the membership criteria?

- Ineffective
- Somewhat Ineffective
- Neither Ineffective nor Effective
- Somewhat Effective
- Effective
- I don't know

30. How well does new member orientation prepare members to fully participate in planning body activities and understand their expected roles and responsibilities?

- Very Well
- Well
- Fair
- Poor
- I don't know

31. How effectively does the [HIV planning body] integrate new members into planning activities after orientation? (e.g. engagement in discussions or invitations to join committees)

- Ineffectively
- Somewhat Ineffectively
- Neither Ineffectively nor Effectively
- Somewhat Effectively
- Effectively

<u>[HIV Planning Body] Collaboration and Impact on the HIV Epidemic</u>

Please respond to the following questions with your honest opinion.

32. The [HIV planning body] could improve communication and collaboration with the following external stakeholder entities:

- State health department

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- Local (city/county) health department
- Other planning bodies in the region
- Ryan White Administrator/Recipient
-
- The [HIV planning body] does not need to improve communication/collaboration with external stakeholders.

33. In what ways could the [HIV planning body] improve about its communication and collaboration with external stakeholders?

____

34. How well does the [HIV planning body] incorporate community voices, specifically those affected by the HIV epidemic, in developing HIV planning priorities and objectives?

- Poorly
- Somewhat poorly
- Neither poorly nor well
- Somewhat well
- Well

Why? Has Covid-19 impacted this?_______________________________

35. List three strategies that the [HIV planning body] currently uses to incorporate community voices in planning.

____
____
____

36. How severely has the [HIV planning body] been impacted by COVID-19?

- Not at all
- To a small extent
- To some extent
- To a great extent
- To a very great extent

In what ways? _________________________________

37. How effective has the [HIV planning body] been in planning for current and future impacts of COVID-19 on HIV planning?

- Ineffectively
- Somewhat Ineffectively
- Neither Ineffectively nor Effectively
- Somewhat Effectively
- Effectively

38. How effectively is the [HIV planning body] in integrating new issues and priorities impacting people with HIV overall into its activities (e.g. Black Lives Matter)?

- Ineffectively

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- Somewhat Ineffectively
- Neither Ineffectively nor Effectively
- Somewhat Effectively
- Effectively

Why or why not? ___________________________________

39. How effectively does the [HIV planning body] translate meeting activities into tangible deliverables that impact community wellbeing, state and local coordination, etc.?

- Ineffectively
- Somewhat Ineffectively
- Neither Ineffectively nor Effectively
- Somewhat Effectively
- Effectively

40. What do you perceive to be the [HIV planning body]'s greatest ...

- Successes (List up to three.):
  ____
- Areas for Improvement (List up to three.):
  ____

41. List three primary ways the [HIV planning body] is helping to end the HIV epidemic.

____
____
____

Appendix 2. Key Informant Interview Guide

**Note: The below KII guide is meant as a large template of questions. The number of questions will be trimmed down significantly in accordance with the needs/specifics of each planning body.*

The following key informant interview (KII) guide is part of a mixed-methods assessment of your current HIV planning practices, structure, and stakeholder engagement efforts. This process will help your HIV planning body better understand and improve its role in ending the HIV epidemic. Your participation and voice in this assessment process is essential. We will be conducting several key informant interviews and administering an anonymous, online survey to collect feedback.

<u>You have been selected as a key informant interviewee</u>. Please let me know when you are available for a 60-minute phone interview between the dates of _____ and _____. All information collected during your interview will be de-identified and reported in aggregate to ensure your confidentiality. We value your honesty and transparency in this process.

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Demographics/Background:

- What is your current title/role?
- How many years have you worked in the HIV field?

Current Role/Engagement with [HIV planning body]:

- Why did you join the [HIV planning body]?
- How many years have you served on the [HIV planning body]?
- What committee(s) do you serve on? Do you serve in a leadership role?
- How long do you plan to stay on the [HIV planning body]?
    - Do you anticipate ending your term of service from the [HIV planning body] in the 1-2 years? (If so, why?)
- What do you see as your main purpose or contribution to the [HIV planning body]?
- What is the biggest obstacle(s) you've encountered to fully engaging with the [HIV planning body]?

HIV Planning Purpose/Effectiveness:

- What would you define as the state/local health department's key roles in HIV planning?
- *[Optional for Part As]* What would you define as the Ryan White HIV/AIDS Part A Program recipient's key roles in HIV planning?
- How would you describe the [HIV planning body]'s relationship with your health department and/or Ryan White HIV/AIDS Program Part A recipient?
- What would you define as the community member's key roles in HIV planning?
- How would you describe the [HIV planning body]'s relationship with the communities affected by the HIV epidemic?
- Do you believe that the [HIV planning body] (as a whole) is currently fulfilling its intended role? Why or why not?
- How does the [HIV planning body] currently measure effectiveness/success?
- What more could be done to ensure that the [HIV planning body] translates meeting activities into measurable, tangible actions?
- What impact has Covid-19 had on the activities and functions of the [HIV planning body?]
- How effectively has the [HIV planning body" integrated shifting priorities due to Covid-19 into its activities? What more should be done?
- Is there anything missing in the Statement of Needs that needs to be addressed
- Are there gaps in the community that aren't being filled?
- Are there sufficient support services being prioritized in the community?
- Does you PB have a formal structure in place to assess the quality of care and prevention services in the community?
- Do you feel that the PB sufficiently represents all its geographies?
- Are there any areas that are not getting sufficient attention?
- Is there an MOA between the contract administrator and the PB members—one that clearly outlines the objectives of the relationship, detailing data…
- What is the relationship between the PB and the contract admin and health department?
- Do you have access to relevant and current data to guide your planning efforts?

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- Is this data distributed equally among the PB?
- i.e.program improvement includes supportive services linked to access and adherence to medical, applicable EIS prevention care; and demographic, clinical and utilization data are used to evaluate and address characteristics of the local epidemic
- Is your PB connected to all parts of the RWP system and is there open communication between groups?
- Are your equipment, facilities, IT, materials and supplies up to date and accessible?
- How do you measure assessment success? Are there timelines to your CQI/QA?
- Can you describe your QA process/structure? Do you have one?
- Alignment, adequate time, clear goals, congruence of resources and scope and an objective assessment of the likelihood of success
- How do you communicate out to your Community? Providers?
- Does your PB appropriately assess the extent to which HIV health services are consistent with the most recent Public Health Service, USPSTF guidelines for the treatment of HIV disease and related opportunistic infections; What about Prevention alignment?

[HIV planning body] Governance and Structure:

- Do you think the current structure of the [HIV planning body] is effective in helping the [HIV planning body] reach its goals? How could it be more effective?
- Do you think the current bylaws are effective in helping the [HIV planning body] reach its goals? How could they be more effective?
- Do you think bylaws/policies are representative of the current governance and role of the [HIV planning body]?
- Do you think the planning body is structured in a way that encourages participation from all members?
    - If not, how could it be structured to be more inclusive and welcoming to more voices?

HIV Planning Engagement/Membership:

- Do you believe the [HIV planning body] effectively incorporates community and stakeholder voices into its planning? Why or why not?
- What do you perceive as an obstacle to engagement and/or recruitment of [HIV planning body] members?
- What do you see as the ideal (most effective) skill set for a member of the [HIV planning body]?

Integrated Planning and Ending the HIV Epidemic Planning:

- How has the CDC/HRSA integrated planning guidance affected the [HIV planning body]'s functions?
- How have you been engaged in the development and implementation of [your state/jurisdiction's] Integrated HIV Prevention and Care Plan?
- How do you anticipate the development of [your state/jurisdiction's] Ending the HIV Epidemic, Getting to Zero, and/or Fast Track Cities Plan(s) will affect the membership, engagement, or role of the HIV planning body?

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- How will the [HIV planning body] contribute to the development of [your state/jurisdiction's] Ending the HIV Epidemic, Getting to Zero, and/or Fast Track Cities Plan(s)?
- Are [HIV planning body] members serving on a separate Ending the HIV Epidemic, Getting to Zero, and/or Fast Track Cities planning council/group(s)?

Looking Toward the Future:

- How do you feel the [HIV planning body] should move forward to operate more effectively or improve the group overall?
    - What will be the biggest roadblocks/challenges to making this happen?
- What additional information, resources, and expertise could <u>you</u> contribute?
- What type(s) of training/technical assistance do you think [HIV planning body] members (or the health department) need to operate more effectively as a group?

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Planning Body Assessment Steps/ Anticipated Timeline

HealthHIV IHAP-TAC 2020-2021

Key Activity	Anticipated Start Date	Anticipated End Date
Kick-off call with planning group leadership and other key stakeholders identified by point-of-contact to outline objectives and intended outcomes	11/16/20	12/18/20
Request/review documentation (e.g. Orientation & Mentorship materials, bylaws)	12/1/20	12/21/20
Identify individuals for key informant interviews (4-6 ppl)	1/4/21	1/12/21
Adapt online survey and interview guide for jurisdiction	1/4/21	1/29/21
Develop communication plan/strategy to engage membership (gain buy-in)	1/4/21	1/12/21
Distribute the online survey (via key points of contacts)	2/1/21	3/1/21
Conduct KIIs	2/1/21	3/1/21
Analysis of survey and KII findings	3/1/21	3/29/21
Review initial findings with key stakeholders/leadership	3/29/21	4/16/21
Finalize report	4/19/21	4/30/21
Hold meeting with planning group members to present findings and prioritize next steps	5/3/21	5/28/21
Finalize report with strategies discussed at group meeting	5/31/21	6/28/21

North Dakota Community Planning Group Assessment

Technical Assistance for HIV Planning

February 2019

Developed by HealthHIV on behalf of the North Dakota Department of Health

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BACKGROUND

In Fall 2018, the North Dakota Department of Health (NDDoH) and North Dakota Community Planning Group (NDCPG) leadership requested HealthHIV to provide technical assistance (TA) to evaluate and review effectiveness of the integrated HIV prevention, care, and viral hepatitis planning group's structure, bylaws, responsibilities and function. The TA delivery will include a comprehensive assessment, a formal presentation at NDCPG bi-annual meeting in February 2019, and recommendations for revisions and upgrades of planning group expectations and responsibilities, including the membership, structure, and policies/procedures.

Logistics & Responsibilities

HealthHIV, a TA provider funded by the Centers for Disease Control and Prevention (CDC), assists state/local health departments, HIV planning groups, ASOs/CBOs, and healthcare organizations in areas such as community engagement, organizational development, program integration, healthcare reform planning, high-impact prevention, clinical integration in prevention, public-private partnerships, and much more.

HealthHIV, based in Washington, DC, developed and implemented a mixed method assessment involving collecting and analyzing quantitative (e.g., online survey) and qualitative (e.g., key informant interviews) data from key stakeholders involved in HIV planning in North Dakota. NDDoH and the NDCPG leadership facilitated engagement and communication with CPG members and external stakeholders throughout the three-week assessment process.

Objectives

The goal of the TA is to provide an external assessment of the North Dakota Community Planning Group to determine the effectiveness of the planning body structure, bylaws, policies, and procedures. The key objectives that will be achieved are:

- Review criteria to assess effectiveness of NDCPG, including structure, membership, community engagement, and monitoring/tracking impact.
- Discuss model practices and key recommendations regarding NDCPG operations.
- Present implications and findings from assessment with full NDCPG membership to encourage consideration, adaptation and/or implementation of recommendations.

DOCUMENT SCOPE

The following document provides a summary and analysis of the information gathering and assessment process, recommendations for NDCPG structure and process improvement, and recommendations for future TA activities. *Note that although HealthHIV identified areas for TA/CBA delivery, this particular effort does not include implementation of recommendations or follow-up TA/CBA at this time.*

INFORMATION GATHERING

Information-gathering activities were implemented among key NDCPG sources, including the state appointed co-chair, community co-chair, and membership committee lead. HealthHIV conducted numerous calls with NDCPG co-chairs to discuss: the scope of TA activities; outline objectives and intended outcomes; review requests for documentation; gain clarification on CPG structure, policies, and procedures; and, ensure full cooperation and clear communication with NDCPG member regarding the TA activity.

Information was collected via email, and included the following NDCPG documentation:

- Acronym Guide
- Executive Board & Committee Listing
- Conference Application Form
- Conferences & Workshops
- Conflict of Interest
- Confidentiality Contract
- Conflict of Interest Disclosure Form
- Glossary of Terms
- Meeting Protocol
- Membership Application Form
- Member Contact Information 2019
- Member Recognition
- Membership Years of Service
- NDCPG Bylaws
- Orientation & Mentorship (including list of orientation materials)
- Outreach Activity Form
- Outreach Events
- Regional Taskforces
- Regional Taskforce Map
- Reimbursement
- Taskforce Meeting Summary
- Timetable of Tasks

NDCPG SURVEY AND KEY INFORMANT INTERVIEWS

The formal assessment of NDCPG was conducted through online surveys and individual phone interviews. HealthHIV implemented two assessment modalities concurrently in January 2019, which included an anonymous online survey of the full NDCPG membership and phone interviews with a diverse group of members, including voting and non-voting members. Ultimately, the assessment and discussion at NDCPG's in-person meeting will lead to a better understanding of how to ensure and improve NDCPG's effectiveness and role in ending the HIV and viral hepatitis epidemics.

Overview of NDCPG Member Survey

The purpose of the online survey instrument was to provide NDCPG with information for reflection, discussion, planning, and development to improve the group's practices, structure, and community engagement efforts. HealthHIV asked survey participants to provide thorough, thoughtful, and truthful answers. All answers to the survey were anonymized and reported in the aggregate to protect confidentiality of NDCPG members.

The survey included 24 questions (17 quantitative and 7 qualitative/open-ended) related to: membership demographics and skills; effectiveness of NDCPG structure; NDCPG recruitment

and orientation activities, relationship with external stakeholders, and key successes and areas for improvement.

HealthHIV and NDCPG leadership reached out to 17 members and a total of 14 individuals responded to the survey. Of those 14 respondents, 36% (5) were affiliated with the state or local health department, 29% (4) with an ASO/CBO, 21% (3) with a healthcare organization, and 14% (2) not affiliated with a specific organization type.

Overview of NDCPG Key Informant Interviews

HealthHIV conducted key informant interviews to further the participation and voice of NDCPG members in the assessment process. A diverse group of perspectives (five members) were asked to participate; new and seasoned members, government and community, as well as process-holders and committee leads. All qualitative information from the interviews was de-identified and aggregated. The interview tool consisted of 26 open-ended questions, which could be completed within 60 minutes, and included discussion of: member background; current engagement an role with NDCPG; HIV planning purpose and effectiveness; NDCPG membership; and, future aspirations/anticipated challenges.

Summary of Findings

Findings from the complete assessment were shared at the NDCPG's February 2019 meeting. The following is a narrative summary of the survey and key informant interview data.

Member Demographics

A majority of the members reside in urban areas (50%) followed by rural (36%) and suburban (14%). A majority of members identify as White/Caucasian (86%), male (57%), and LGBT (50%, including 43% MSM). There is moderate representation of persons living with HIV (21%), currently/formerly homeless (21%), current/former injection drug user (21%), currently/former sex worker (14%), and baby boomer (14%).

None, or very few, of the members that responded to the online survey self-identify as members of the following high-risk demographic populations:

- Black/African American
- Hispanic or Latino
- Foreign Born/New American
- Youth (1995-2004)
- Transgender/Gender non-conforming
- Person living with viral hepatitis

Self-reported Skills of Current Members

The listing of member skill levels below is based on respondents' self-report of expertise in the following public health and HIV/viral hepatitis-related subject areas.

Most Skilled (Intermediate to Advanced)	Basic Skills	Least Skilled (No Skills)
• Biomedical HIV prevention advances (50%) • Advocacy (43%) • HIV outreach and community health (43%) • Community organizing (38%) • LGBT health (36%) • Social media and marketing (36%) • Epidemiology and data analysis (36%) • Housing and homelessness (36%)	• Primary health care (64%) • HIV care and treatment (64%) • Substance use and addictions treatment (64%) • Indigenous/native population health (64%)	• Corrections/law enforcement (50%) • Federal health policy (46%) • Faith-based communities (36%) • Minority-focused services (29%) • Behavioral or social sciences (29%) • Research and evaluation (29%)

Other reported skills included: real-world experience related to living with HIV and stigma; viral hepatitis; community volunteering; tribal health education; STD screenings.

Skills Most Important for Members

HealthHIV asked which skills sets, values, or perspectives are most important for members to have to meaningfully engage on the NDCPG. Responses are summarized in the chart below:

• Personal experience, personal engagement and willingness to be active as a member, personal investment	• Be able to be a voice of your community – be comfortable speaking on your community and reflective reason as to why you are there
• Medical provider (to field medical-centered questions and provide input from that perspective)	• Involved, engaged, active participation in meetings and as a representative of NDCPG at outreach and testing events
• Strong communication skills	• Not selected just because they work for a specific agency
• Willingness to collaborate and work with a diverse group of people	• Someone who wants to help their community or someone who is a searching for community
• Baseline knowledge of the HIV epidemic and current guidelines (moving beyond condom distribution to PrEP, U=U, etc.)	• Someone who is engaging in learning and educating themselves on HIV (thirst for knowledge)

NDCPG Structure

HealthHIV explored several areas of the current NDCPG structure through review of documentation, the online survey, key informant interviews, and conversations with the NDCPG co-chairs.

Health Department of Community Member Roles & Responsibilities in HIV Planning

HealthHIV asked members to share their perspectives on the roles and responsibilities of the health department and community representatives in the HIV planning process. Many noted that expectations of members have changed, and there should be more clarification of roles and needed investments of the membership. Interviewees seemed better able to articulate and specific activities and responsibilities of the health department, but shared a broader and more vague description of the community role in planning.

Health Department Role	Community Member Role
• Should have less of a role than community on the planning group – not overshadowing community • Provide updates on data and epidemiology trends • Share information on resource allocation and moves funding • Promotes events and community engagement opportunities • Explores opportunities to decrease stigma • Write IPCP and objectives • With minimal involvement from the community the HD is asked to do a lot • Provides medical services • Ensures buy-in, collaboration, participation, and communication with key government agencies	• Has evolved to ASO/direct service provider role – carrying out activities of IPCP • Advisory role for most of IPCP development and implementation • Share community voice to inform where HD should focus efforts • Ensure health department does not lose the human touch • Assist HD in being voice <u>OF</u> and <u>TO</u> the community by engaging in awareness events

Regional Taskforces

Overall, the NDCPG members agreed that the Regional Taskforces have not been effective (scoring average of 4 out of 10). The majority of respondents (71%) scored the regional taskforce structure ineffective based on the Likert scale. Rational for its effectiveness and ineffectiveness are:

Ineffective	Effective
• Under-resourced • Either government-based or community-based • Expectations and engagement of members • Accountability for participation • Communication between task forces • Meeting inconsistently	• Loyalty & commitment • Helps keep health department updated on local/regional HIV health issues • Helps educate the communities • Discussions are productive and follow-up is effective

• Central Region and Northern Region lack participation • Some more active than others	

Key informant interviews support the need to adapt or dissolve the regional structure due to lack of direction, engagement, and diversity/representation within regions. Few activities are being accomplished at a regional level beyond sharing of information, resources, and events. If the regional structure were to continue, a clearly outlined purpose and expectations needs to be developed to ensure the process is contributing to HIV planning. At this time, few members are able to articulate the expectations, activities, or rationale for the regional groups.

Committees

Data from the survey indicates that members would consider, and possibly preference, changes in the NDCPG committees. In response to which committees might be most effective, the members recommended: *Community Engagement & Education* (86%); Community Services/Needs Assessment Committee (50%); Executive Committee (36%); Membership Committee (27%); Evaluation Committee (21%); and, Ad Hoc Committee (21%). Two of the committees selected are existing committees, and none of the respondents wrote in additional recommendations.

Meetings

Data also suggested that the majority of members (36%) support the current bi-annual meeting schedule, however, 43% (6) would participate in three or four meetings annually and 21% (3) would participate in ten meetings. The preferred format for meetings is in-person, and 71% would participate via web meeting with video conferencing and fewer than half (43%) would participate via web meeting without video conferencing.

Bylaws, Policies & Procedures

A majority of members (57%) feel that the current bylaws, policies, and procedures are at least somewhat effective (scoring average of 7 out of 10), however 43% of respondents had a neutral opinion of the effectiveness of written NDCPG policies. Members agree that the group operates according to written policies and procedures, and note that written bylaws have been effective for new members. It also was noted that the bylaws are clear and easy to understand.

The bylaws will constantly need to evolve in order to remain relevant, and the newest iteration (2017) is moving them towards that. The suggested updates to be made are in: taskforce groups, expectations of a CPG member, and involvement of the HD in the CPG. One member felt that the recent bylaws/policies/procedures change might have caused the group to lose members.

NDCPG Membership

Overall, respondents noted that the NDCPG membership may be agency-heavy and lacking complete involvement from the community. Diversity on the group needs to be addressed to

include broader stakeholders addressing social determinants of health, other geographic areas, and populations most impacted by HIV and viral hepatitis and the providers serving them.

Recruitment

The majority of NDCPG members became members through a referral or recommendation from a current member (61%). Two respondents learned about NDCPG through the NDDoH/CBO/health center, two requested information due to personal and professional interests, and one individual learned of NDCPG online. None of the members were recruited at outreach events, which may be a missed opportunity for recruitment in the future. Key informant interviews supported the survey data, indicating that a NDCPG member, friend, colleague, or case worker/NDDoH representative recruited most of the current members.

The primary reasons for current members joining NDCPG:

- Personally affected and/or member of target population (MSM, PLWH)
- Previous experience with serving on boards for HIV prevention and equality
- Desire educate and engage the community, including the LGBT, immigrant, and/or indigenous populations
- Need to serve those affected in the community who were not getting assistance or education
- Bring forward concerns of PLWH in the state (first-hand concerns and challenges)
- Seeking to reduce stigma in community
- Passionate about mission and work
- Requirement or benefit professionally – take conversations and information back to organization

Respondents did not highly rate the current recruitment efforts of the NDCPG (average 4 of 10). Although a majority (71%) rated recruitment ineffective, the responses varied. Three respondents rated the recruitment efforts highly and several were somewhat positive about how NDCPG currently recruits members.

Observed challenges to new member recruitment include:

- NDCPG taking a passive, rather than active, approach to recruiting new members
- Missing opportunities to discuss NDCPG and recruit members at outreach and testing events and in non-traditional settings (e.g. adult bookstore)
- Identifying and engaging someone who has access to individuals out in rural communities and native populations
- Need for new voices and perspectives to move beyond status-quo
- Stigma within target populations (New American, Native/Indigenous)

Retention & Engagement

The majority of current members (43%) intend to stay on the NDCPG for 10 or more years, demonstrating a strong commitment to the group and HIV planning process. Only one member

plans to retire in one to two years. However, several members indicated they “don’t know” what their long-term plans are for engagement with the NDCPG, which should be explored further. The key informant interviews indicated this uncertainty could be due to individuals being unsure about the longevity of their current professional position, which impacts NDCPG membership.

Members noted that some individual members have exceeded expectations for engagement and others are less engaged, and possibly less interested, invested, or burnt out. Some members offered their hope to be more meaningfully engaged by NDCPG in the future, such as through more outreach events and walks, and webinars and online learning opportunities.

Perception also exists that there are not enough members to complete tasks, which creates burden on some members. Some members do not seem engaged year-round in activities, e.g. unresponsive to communications. It is noted the limited distribution of tasks and responsibilities – in part due to lack of engagement—requiring the NDDoH to take on most of the work.

There were varied responses to NDCPG engagement with the state Integrated HIV Prevention and Care Plan (IPCP). Many report great involvement in the development of the most recent IPCP and advisory role on how the state will meet objectives. However, members also report lack of discussion on how to move activities forward on a regional level, and there is limited follow-up or discussion of realistic annual goals and objectives.

Orientation

Respondents rated the current member orientation of the NDCPG as average (average 5 of 10). Although a majority (64%) rated member orientation ineffective or neutral, the responses varied. Three respondents rated the member orientation efforts highly and two were somewhat positive about how NDCPG currently conducts orientation with new members. Several individuals indicated that new members would benefit from a more comprehensive and interactive orientation process prior to their first in-person meeting to ensure new member is fully briefed to be able to engage meaningfully and voted informed.

Respondents reported the following strengths and weaknesses in NDCPG’s current member recruitment, orientation, and retention activities:

Strengths	Weakness
• Welcoming/very open to new members • Long tenure of members • Currently have bylaws and a policies and procedures manual • NDCPG orientation is very thorough and reviews rules and regulations for the CPG members	• Diversity of members, including those impacted by the epidemic such as individuals impacted by HIV/AIDS • Members aren't representative of the epidemic currently and more work to recruit these persons are needed

• Lots of people interested in becoming members • Outreach by members for recruitment • Flexibility of group helps with retention • Small group, so you can get up to speed with the process quickly • Succession • Training	• Recruiting individuals that are geared towards our mission • Lack of community willingness to be involved • Hard to find people willing to devote the time and volunteer hours needed • Difficult recruiting members from more rural parts of the state • Member orientation and selection • Promotion efforts

Community Engagement/Representation

The majority of respondents (64%) rated how the NDCPG incorporates and involves community voices unfavorably and ineffectively, however, the ratings varied significantly from zero to ten. Two respondents rated community engagement highly effective. Key informant interviews pointed to lack of engagement of specific target populations, many of whom are reportedly very private and they do not like to share their status for fear of being isolated from their own community. One member noted that without engagement from the NDCPG or NDDoH, many of these PLWH would be feeling alone in the community with no one is reaching out to engage them. The key community voices that respondents think are missing from NDCPG are:

Key Perspectives/Backgrounds	Key Skills /Professional Experience
• New American (Foreign Born), including African Migrants (Eastern Africa, Western Africa, Somalia) • Minorities • African American • Indigenous/Native American/ American Indian • Transgender Community • People living with HIV • People living with viral hepatitis • “Voices of Addiction”/Substance Users • Injection Drug Users • Personal and vested interest	• Healthcare Providers in HIV/HCV (physician, RN) • Substance Use Treatment Providers • Mental Health Provider • Housing Provider • Community Service Organizations • Media • Marketing • Development • *Note: they do not need to be affiliated with a specific organization*

NDCPG Relationships

Respondents rated NDCPG’s relationship with the NDDoH very favorably (average 7 out of 10). Only three respondents rated the relationship less the neutral. However, the NDCPG’s relationship with external stakeholders/partners in HIV and viral hepatitis was very average (average 5 of 10)—responses varied significantly from 2 to 10.

Suggestions provided by survey and key informant interview participants of which additional external stakeholders should be engaged in HIV planning include:

▪ Mental health and substance abuse organizations	▪ Financial assistance agencies, e.g. Community Action
▪ State Medicaid	▪ Human services organizations
▪ Housing agencies	▪ Primary care/Family Practice sites

Monitoring and Tracking Effectiveness & Outcomes

NDCPG Contribution to Ending the Epidemics
The majority of members believe that the NDCPG is tracking on the right path to impact the HIV and viral hepatitis epidemics. Citing this past year's HIV Awareness Walk that was well-attended, members would like to see activities like that move around the state to its four major cities. However, they do not have any specific metrics or measurements that are outlined to accomplish in order to move things forward. The NDCPG does try to collect data and review the number of testing events, the number of outreach activities, and tries to expand on the activities each year (e.g. make testing more available, make PrEP more available).

As an advisory group and voice of the community, the NDCPG members recognize they need to push for better HIV care services and HIV care engagement in the planning process in order to end the HIV epidemic. It also is noted that NDCPG will be challenged to contribution to ending the epidemics without the right community engagement, communication/messaging strategy, and advocacy and education within the conservative state government. The key strategies that NDCPG must move forward are to educate and reduce stigma in the community around HIV.

- Example: One goal for 2020 is to increase PrEP awareness and uptake, however there are few or no materials or communications to disseminate. Physicians in primary care/family practice settings must be engaged and educated (i.e. academic detailing), so they can identify individuals at high risk for HIV and prescribe PrEP.

Improvements and Future Trends

NDCPG's Overall Success and Challenges
The listing of key successes and challenges of the NDCPG is based on both survey and key informant interview responses.

Successes	Areas for Improvement
• First HIV/AIDS Walk** • Revision of bylaws • Unification of the group • Increased awareness of all infectious diseases • Increased HIV testing • Continued outreach in community • Community engagement	• HIV services review • Member recruitment, selection, and development** • More representative and diverse voices and partnerships, i.e. recruiting the "right" members* • Involvement of community • Increase awareness events, such as HIV walks, conference, health fair, etc.

• Community involvement and input • Involvement in Pride events • Group is committed to making change • Continuity • Successful media campaigns focused on sexual health • Engagement in development of integrated planning strategies • Representation of state government and PLWH on the group • Sharing of ideas that can be implemented in different parts of the state • Freely able to express opinions	• More testing options/events* • Stakeholder and specialist input • Meeting in-person • Spread out across the state impacts development of statewide initiatives • Lack of engagement and voice from HIV care providers • Perceived lack of time/commitment o additional tasks • Innovation in identifying new activities or outreach venues ("tunnel vision: on "mundane") • Engage people "where they are at" • Increase testing/outreach at NEX, harm reduction sites, for IDUs

Suggestions provided by survey and key informant interview participants to improve the effectiveness of NDCPG include:

▪ Review its roles and responsibilities, and set a purpose/outcome statement at the start of the meeting	▪ Get new members involved to help carry the load and relieve the stress of commitment
▪ Advocate to NDDoH for more engagement of HIV care staff at outreach activities to offering resources to PLWH	▪ Acknowledge key challenges (political and financial), and seek work-arounds
▪ Make assignments, hold them responsible so that everyone is engaged, and follow-up on tasks	▪ Re-strategize and innovate to improve reach to those most at risk during testing events
▪ Ensure strong leadership and clear direction for all aspects of NDCPG operation (from facilitation to structure)	▪ More consistent and structured communication (all around)
▪ Must engage physicians providing HIV care – the group may not necessarily have to recruit providers as members but could instead invite them to sit-in on meetings or present	▪ Encourage a time for sharing successes and opportunities for improvement/ next level
▪ More focus on national HIV and viral hepatitis testing days and HIV awareness days	▪ Seek assistance with developing educational materials, that can be distributed on PrEP, media campaigns and awareness activities

ASSESSMENT CONCLUSIONS

Findings from the review of documentation, online survey, and key informant interviews point to several areas for improvement, as well as highlight the success and effectiveness of NDCPG and its HIV and viral hepatitis planning efforts. For the purposes of this initial assessment report, conclusions will focus on areas for improvement, including NDCPG structure, membership, community engagement, and monitoring and tracking effectiveness. Specific

recommendations will be detailed and discussed following the February 2019 in-person meeting.

1. ***Adapt NDCPG Structure to Current Environment and HIV Planning Needs***:

Opportunities
➢ Task assignment, monitoring, and task shifting
➢ Review committees and consider relevance, current needs, and member interest
➢ Adaptation of regional taskforces for a community engagement model

2. ***Ensure Diversity, Inclusion, and Knowledge Transfer among NDCPG Membership***:

It is important to note the impacted populations not represented, or under-represented, in NDCPG membership include: Native American/indigenous; Black/African American; youth; transgender/gender non-confirming; person living with viral hepatitis; and, foreign born.

Opportunities
➢ Succession planning, alternates and non-voting members
➢ Targeted, diversified recruitment strategies
➢ Review selection criteria and skills matrix
➢ Training/professional development opportunities

3. ***Promote Community Engagement in HIV and Viral Hepatitis Planning***:

Opportunities
➢ Utilize regional model for engaging hard-to-reach populations
➢ Consider scope of resource shifting to support community engagement

4. ***Implement Activities to Monitor and Track Effectiveness of NDCPG***:

Opportunities
➢ Annual Satisfaction survey of members and NDCPG effectiveness
➢ Develop metrics and tracking mechanism for bi-annual meetings
➢ Create system for sharing IPCP updates and next steps with NDCPG

RECOMMENDATIONS

HealthHIV and the NDCPG leadership convened a half-day meeting of the NDCPG on Friday, February 8, 2019. The objective of HealthHIV's in-person engagement was to present findings and possible implications from the assessment to NDCPG membership in order to discuss and consider implementation of recommendations. HealthHIV provided the written report (above)

and reviewed key findings from both the online survey and key informant interviews. During the presentation of findings, HealthHIV facilitated a discussion among members to gauge reactions and gain/assess consensus regarding areas for improvement. Guided by HealthHIV facilitators, the NDCPG members agreed to identify areas for improvement regarding: NDCPG structure; Membership Diversity; Community Engagement; and, Monitoring and Evaluation of Effectiveness. Below is a complete listing of the strategy recommendations identified and written by NDCPG members during the group brainstorming activity. Following the brainstorm, HealthHIV facilitators asked NDCPG to use up to five (5) votes each to indicate which strategies should be prioritized. The list below notes the "votes" with an asterix (*) and the priority activities in **bold**.

1. Ensure NDCPG Structure is Relevant to Current Environment and HIV Planning Needs

Strategy 1: Increase member accountability ******
- Outline process in bylaws to assign specific tasks to members and include report back
  - Each member should have a task to complete for the following bi-annual meeting
  - Considerations: How do you ensure accountability to tasks? Ramification/consequence in bylaws? How are tasks assigned to ensure relevance to integrated plan?

Strategy 2: Provide clear written expectations to members
- Create and implement member commitment form

Strategy 3: Re-define role, responsibility, and relevance of regional taskforces (fix or replace)
- Focus taskforce activities on community engagement
- Replace taskforce meetings with statewide video meeting(s) that are a maximum of two hours long

Strategy 4: Implement one statewide CPG meeting to be held via video conference perhaps in between the two in-person

Strategy 5: Current committees could be more active (meet more either by phone/video/in-person)

Strategy 6: Keep all members engaged and informed between bi-annual meetings
- **Utilize Facebook messenger feeds for communication and information-sharing between members ****
- Bi-monthly (every other month) newsletter/communication *
  - Members report on upcoming events and/or progress on activities

Strategy 7: Facilitator should have a vote

2. Ensure Diversity, Inclusion, and Knowledge Transfer among NDCPG Membership

- **Strategy 1: Increase CPG participation in events or groups that reach diverse audiences/populations that can contribute to understanding of cultures and needs**

Empower members to attend events or require members to attend events ***

Create calendar to track member attendance

Where? Consider focus groups at SSPs*, engagement of Somali, Transgender, American Indian, cultural events, faith-based events*, health care providers

- Strategy 2: Develop talking points for members to use at outside events
- **Strategy 3: Create membership/skills matrix ****
- **Strategy 4: Develop postcard/palm card with information about CPG members ****
- Strategy 5: Actively invite public and/or stakeholder groups to attend and provide input without being members *

  Letter to all PLWH with CPG info and how to participate

<u>3. Promote Community Engagement in HIV and Viral Hepatitis Planning</u>

- **Strategy 1: Enhance Facebook presence to improve engagement of outside stakeholders *******

  Linking to Facebook/Twitter/Instagram where needed

  Add Ryan White, hepatitis C, STDs, and other events (e.g. pictures of the walks)

  Fix website
- Strategy 2: Develop billboard/promo campaign for awareness day(s), testing day(s), HIV/health facts *
- Strategy 3: Use CPG members to education attendees during testing events ("the more you know")
- Strategy 4: Increase involvement with other social groups *

  College 10% Societies
- **Strategy 5: Utilize annual events to engage community (e.g. annual walk, masquerade ball, dance that engages youth) *****
- **Strategy 6: Implement focus groups with parents, high school students or engage at school events (e.g. "can we talk", tell it to me straight) *****

  Meet with and educate school nurses
- **Strategy 7: Increase advocacy at legislative level on behalf of CPG (e.g. decriminalization) *****
- Strategy 8: Disseminate/engage around PrEP education/materials
- Strategy 9: Focus regional taskforce activities on community events

<u>4. Implement Activities to Monitor and Track Effectiveness of NDCPG</u>

- Strategy 1: Develop and implement annual member satisfaction (consider meeting evaluations differently)
- Strategy 2: Provide local and state date in a more exciting and more timely way (i.e. data visualization) *
- Strategy 3: Add CPG as a responsible party to more activities on the integrated plan

- Strategy 4: Seek training and/or feedback on how to assess and measure stigma (e.g. utilize focus groups of PLWH and American Indian) *****
- Strategy 5: Track CPG engagement per member or taskforce group (e.g. number of events hosted or attended) *****
  Take accountability and take credit for work
- Strategy 6: Find a way to measure the use of PrEP and its impact (seek data from state Medicaid, insurance, IHS, other national groups) *****

FOLLOW-UP/NEXT STEPS

HealthHIV conducted a follow-up call with NDCPG one month after the assessment to determine next steps and any progress the NDCPG had made on the listing of recommendations. At that time, the NDCPH had begun documenting (in writing) more detail on member roles/responsibilities, further discussed transitioning Regional Taskforces to a community engagement model, and had identified four (4) key activities for the Executive Committee to accomplish by March 15, 2019. In addition, they NDCPG added a third meeting for the year (May 20th) to allow an opportunity to check-in on progress. HealthHIV provided some additional guidance by phone and email, including a list of possible private sector grants/ scholarships to attend national conferences. Since the NDCPG engagement, HealthHIV also engaged the NDCPG co-chair as a presenter at HealthHIV's 2019 SYNChronicity National Conference and is utilizing the NDCPG assessment tools to pilot a CPG assessment with three additional jurisdictions.

Planning CHATT
Recruitment and Retention Learning Collaborative 2021
APPLICATION

The Planning Community HIV/AIDS Technical Assistance and Training (Planning CHATT) project builds the capacity of Ryan White HIV/AIDS Program (RWHAP) Part A planning councils and planning bodies (PC/PB) across the U.S. to fulfill their legislative responsibilities, strengthen consumer engagement, and increase the involvement of community providers in HIV service delivery planning**.** Planning CHATT is now offering learning collaborative TA opportunities that will provide virtual group learning sessions to facilitate knowledge exchange and collaboration among up to ten PC/PBs.

Recruitment and retention of PC/PB consumer members is an ongoing challenge. The Ryan White HIV/AIDS Treatment Modernization Act requires that "not less than 33 percent of Ryan White HIV/AIDS Program (RWHAP) Part A planning councils shall be individuals who are receiving HIV-related services [under RWHAP Part A], are not officers, employees, or consultants" of funded RWHAP Part A providers, and "reflect the demographics of the population of individuals with HIV/AIDS" in the service area*****. To support PC/PBs in this endeavor, Planning CHATT's first learning collaborative will focus on PC/PB member recruitment and retention. The learning collaborative will support PC/PBs in their efforts to develop a recruitment and retention strategy that prioritizes consumers and people of color. Participants will take part in monthly 90-minute virtual learning sessions and will complete post- session assignments. The learning collaborative will take place from January 2021 - June 2021.

***** Section 2602(b)(5)(C)(i)

Who Should Apply

Any PC/PB who would like to strengthen their recruitment and retention strategy may apply. Participation will be limited to 10 PC/PBs, ideally representing a range of geographies and populations served. Selection into this learning collaborative will require a commitment to participate in all activities, including virtual learning sessions and assignments. In addition, each participating PC/PB will be expected to create an Implementation Team to support the development and invention of the recruitment and retention strategy. We recommend that the Implementation Team be 3 - 5 persons and include:

- At least one person who serves in a planning council leadership role (e.g. PC/PB Co-Chairs, Membership Committee members, other committee chairs)
- At least one unaligned consumer member
- One representative from the PC/PB Support (PCS) staff

Commitment and Expectations

Learning collaborative participants are expected to:

- Actively participate in five (5) virtual 90-minute learning sessions and complete related assignments
- Assess their PC/PB's current recruitment and retention efforts
- Share progress toward goals and challenges faced over the 6-month LC period
- Develop or revise a recruitment and retention strategy that includes specific goals and timelines
- Meet as an Implementation Team at least once a month outside of the virtual session to work on assignments related to the recruitment and retention strategy development.

PC/PBs who have full involvement in their teams are likely to see the greatest impact from learning collaborative participation.

Instructions and Key Dates

If you are interested in applying, **please complete the following application in full**, **including the declaration of commitment section** to be attested to by your PC/PB leadership. **Applications must be submitted by December 2nd, 2020 at 5 PM Eastern.**

If you have questions, please email chanel_richmond@jsi.com in advance of the due date.

Application

Please read the application carefully before completing the form.

- Applications may be completed by any Planning Council/Planning Body member who will serve as the Implementation Team lead. However, the application must be attested to by the PC/PB leadership.
- Completed applications should be submitted by **December 2nd.** Applications will be reviewed by Planning CHATT and HRSA.
- Applicants will be notified of their selection into the learning collaborative by **December 11th.**

1. **PC/PB name: ___________________________________**
2. **PC/PB city/county and state: ___________________________________**
3. **Name of Person completing the application: _______________**
   - Length of time on PC/PB
   - Email address
   - Which of the following apply to you? (Check all that apply)
     - Executive Committee
     - Membership Committee
     - Unaligned Consumer
     - PC/PB Support Staff
     - Other:__________________

4. Implementation Team Members (3- 5 members)

- Name
- Length of time on PC/PB
- Email address
- Which of the following apply to this Implementation Team member? (check all that apply)
    - Executive Committee
    - Membership Committee
    - Unaligned Consumer
    - PC/PB Support Staff
    - Other:____

5. Attendance at monthly virtual learning sessions is important to a successful learning collaborative experience. You will need to commit to attend the sessions on the following dates:

- February 25, 2021
- March 25, 2021
- April 22, 2021
- May 27, 2021
- June 17, 2021

5a. Which time of day would your team be available for the virtual learning sessions? (Check all that apply)**.**

- Midday (12pm - 3pm ET)
- Evenings (4pm - 6pm ET)

6. Please identify one recruitment goal and one retention goal your PC/PB has for their participation in this learning collaborative. (Open answers)

- Recruitment Goal:
- Retention Goal:

7. Does your PC/PB currently have a written recruitment and retention plan?

- Yes
- No
- In progress

8. Are there any specific populations that are challenging for your PC/PB to recruit/retain (e.g. unaligned consumers, people of color, youth/young adults, etc.)? If so, please describe.

9. Does your Planning Council/Body have an online presence (e.g. website, Facebook, Instagram, etc.)?

- Yes
- No

- In progress
- If yes, please describe: ____

10. Does your PC/PB have any leadership development and/or mentorship initiatives in place?

- Yes
- No
- In progress

11. Please express your commitment to participate by indicating yes or no to the following statements:

- All participants understand that participation in the learning collaborative requires active participation in five (5) monthly 90-minute virtual learning sessions. __YES ___NO
- All participants understand that participation in the learning collaborative will require the completion of individual and team assignments that will be shared during the virtual learning sessions. ___YES ___NO
- PC/PB leadership will attend every session. ___YES ___NO

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CODE OF CONDUCT

We welcome commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. We create a safe environment that celebrates differences while striving for consensus and is characterized by consistent, professional, and respectful behavior. Our common enemies are HIV and STDs. We strive to be introspective and understand and clarify our assumptions, while appreciating the complex intersectionality of the lives we live. We challenge ourselves to be self-reflective and committed to an ongoing understanding. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We strive for consensus and compassion in all our interactions.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen, don't repeat what has already been stated, avoid interrupting others, and allow others to be heard.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **We give and accept respectful and constructive feedback.**
7) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
8) **We have no place in our deliberations for homophobic, racist, sexist, and other discriminatory statements and "-isms" (including transphobia, ableism, and ageism).**
9) **We give ourselves permission to learn from our mistakes.**

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19)**

DUTY STATEMENT

COMMITTEE CO-CHAIR

(APPROVED 3-28-17)

In order to provide effective direction and guidance for the Commission on HIV, Committee Co-Chairs must meet the following demands of their office, representation and leadership:

COMMITTEE LEADERSHIP:

① Serves as Co-Chair of a standing Commission Committee, and leads those monthly meetings

② Leads Committee decision-making processes, as needed

③ Meets monthly with Executive Director, or his/her designee, to prepare the Committee meeting agendas, course of action and assists Commission staff in the preparation of motions, backup materials and information for meetings, as necessary and appropriate

④ Assigns and delegates work to Subcommittees, task forces and work groups

⑤ Serves as a member of the Commission's **Executive Committee**

MEETING MANAGEMENT:

① Serves as the Presiding Officer at the Committee meetings

② In consultation with other Co-Chair and senior Commission staff member(s), leads the Committee meetings,
- conducting business in accordance with Commission actions/interests
- recognizing speakers, stakeholders and the public for comment at the appropriate times
- controlling decorum during discussion and debate and at all times in the meeting;
- imposing meeting rules, requirements and limitations
- calling meetings to order, for recesses and adjournment in a timely fashion and according to schedule, or extending meetings as needed
- determining consensus, objections, votes, and announcing roll call vote results
- ensuring fluid and smooth meeting logistics and progress
- finding resolution when other alternatives are not apparent
- ruling on issues requiring settlement and/or conclusion

③ Ability to put aside personal advocacy interests, when needed, in deference to role as the Committee's Presiding Officer.

REPRESENTATION:

In consultation with the Executive Director, Committee Co-Chairs:

① May ONLY serve as Committee spokesperson at various events/gatherings, in the public, with public officials and to the media if approved by the Commission Co-Chairs and Executive Director

② Take action on behalf of the Committee, when necessary

③ Generates, signs and submits official documentation and communication on behalf of the Committee
③ Present Committee findings, reports and other information to the full Commission, Executive Committee, and, as appropriate, other entities
⑤ Represent the Committee to the Commission, on the Executive Committee, and to other entities
⑥ Support and promote decisions resolved and made by the Committee when representing it, regardless of personal views

KNOWLEDGE:
① CDC HIV Prevention Program, Ryan White Program (RWP), and HIV/AIDS and STI policy and information
② LA County Comprehensive HIV Plan and Comprehensive HIV Continuum
③ LA County's HIV/AIDS and STI, and other service delivery systems
④ County policies, practices and stakeholders
⑤ Ryan White Program legislation, State Brown Act, applicable conflict of interest laws
⑥ County Ordinance and practices, and Commission Bylaws
⑦ Topical and subject area of Committee's purview
⑧ **Minimum of one year active Committee membership prior to Co-Chair role**

SKILLS/ATTITUDES:
① Sensitivity to the diversity of audiences and able to address varying needs at their levels
② Life and professional background reflecting a commitment to HIV/AIDS and STI-related issues
③ Ability to demonstrate parity, inclusion and representation
④ Take-charge, "doer", action-oriented; ability to recruit involvement and interest
⑤ Unintimidated by conflict/confrontation, but striving for consensus whenever possible
⑥ Firm, decisive and fair decision-making practices

COMMITMENT AND ACCOUNTABILITY TO THE OFFICE:
① Put personal agenda aside and advocate for what's in the best interest of the Commission
② Devote adequate time and availability to the Commission and its business
③ Assure that members' and stakeholders' rights are not abridged
④ Advocate strongly and consistently on behalf of Commission's and people living with and at risk for HIV, interests
⑤ Always consider the views of others with an open mind
⑥ Actively and regularly participate in and lead ongoing, transparent decision-making processes
⑦ Respect the views of other regardless of their race, ethnicity, sexual orientation, HIV status or other factors

2020 MEMBERSHIP ROSTER| UPDATED 11.19.20

SEAT NO.	MEMBERSHIP SEAT	Commissioners Seated	Committee Assignment	COMMISSIONER	AFFILIATION (IF ANY)	TERM BEGIN	TERM ENDS	ALTERNATE
1	Medi-Cal representative			*Vacant*		July 1, 2019	June 30, 2021	
2	City of Pasadena representative	1	EXC|SBP	Erika Davies	City of Pasadena Department of Public Health	July 1, 2018	June 30, 2022	
3	City of Long Beach representative	1	PP&A	Everardo Alviso	Long Beach Health & Human Services	July 1, 2019	June 30, 2021	
4	City of Los Angeles representative	1	PP	Ricky Rosales	AIDS Coordinator's Office, City of Los Angeles	July 1, 2018	June 30, 2022	
5	City of West Hollywood representative	1	PP&A	Derek Murray	City of West Hollywood	July 1, 2019	June 30, 2021	
6	Director, DHSP	1	EXC|PP&A	Mario Pérez, MPH	DHSP, LA County Department of Public Health	July 1, 2018	June 30, 2022	
7	Part B representative	1	PP&A	Karl Halfman, MA	California Department of Public Health	July 1, 2018	June 30, 2022	
8	Part C representative			*Vacant*		July 1, 2018	June 30, 2022	
9	Part D representative			*Vacant*		July 1, 2019	June 30, 2021	
10	Part F representative	1	PP	Jerry D. Gates, PhD	Keck School of Medicine of USC	July 1, 2018	June 30, 2022	
11	Provider representative #1	1	OPS	Carlos Moreno	Children's Hospital Los Angeles	July 1, 2019	June 30, 2021	
12	Provider representative #2	1	SBP	David Lee, MPH, LCSW	Charles Drew University	July 1, 2018	June 30, 2022	
13	Provider representative #3	1	SBP	Harold Glenn San Agustin	JWCH Institute, Inc.	July 1, 2019	June 30, 2021	
14	Provider representative #4	1	PP&A	LaShonda Spencer, MD	Charles Drew University	July 1, 2018	June 30, 2022	
15	Provider representative #5			*Vacant*		July 1, 2019	June 30, 2021	
16	Provider representative #6	1	PP&A	Anthony Mills, MD	Southern CA Men's Medical Group	July 1, 2018	June 30, 2022	
17	Provider representative #7	1	PP&A	Frankie Darling-Palacios	Los Angeles LGBT Center	July 1, 2019	June 30, 2021	
18	Provider representative #8	1	PP	Martin Sattah, MD	Rand Shrader Clinic, LA County Department of Health Services	July 1, 2018	June 30, 2022	
19	Unaffiliated consumer, SPA 1	1	EXC|OPS	Michele Daniels	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
20	Unaffiliated consumer, SPA 2			*Vacant*		July 1, 2018	June 30, 2022	
21	Unaffiliated consumer, SPA 3			*Vacant*		July 1, 2019	June 30, 2021	
22	Unaffiliated consumer, SPA 4	1	EXC|SBP	Kevin Stalter	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
23	Unaffiliated consumer, SPA 5			*Vacant*		July 1, 2019	June 30, 2021	
24	Unaffiliated consumer, SPA 6	1	PP	Pamela Coffey	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	Alasdair Burton (PP)
25	Unaffiliated consumer, SPA 7			*Vacant*		July 1, 2019	June 30, 2021	Thomas Green (SBP)
26	Unaffiliated consumer, SPA 8	1	PP&A	Kevin Donnelly	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
27	Unaffiliated consumer, Supervisorial District 1			*Vacant*		July 1, 2019	June 30, 2021	
28	Unaffiliated consumer, Supervisorial District 2			*Vacant*		July 1, 2018	June 30, 2022	Nestor Rogel (PP)
29	Unaffiliated consumer, Supervisorial District 3	1	SBP	Joshua Ray	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Eduardo Martinez (SBP/PP)
30	Unaffiliated consumer, Supervisorial District 4			*Vacant*		July 1, 2018	June 30, 2022	
31	Unaffiliated consumer, Supervisorial District 5	1	PP&A	Diamante Johnson	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	Kayla Walker-Heltzel (PP&A/OPS)
32	Unaffiliated consumer, at-large #1			*Vacant*		July 1, 2018	June 30, 2022	Tony Spears
33	Unaffiliated consumer, at-large #2	1	OPS|PP&A	Joseph Green	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
34	Unaffiliated consumer, at-large #3	1	SBP	Felipe Gonzalez	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
35	Unaffiliated consumer, at-large #4	1	EXC	Bridget Gordon	*Unaffiliated Consumer*	July 1, 2019	June 30, 2021	
36	Representative, Board Office 1	1	EXC|PP&A	Al Ballesteros, MBA	JWCH Institute, Inc.	July 1, 2018	June 30, 2022	
37	Representative, Board Office 2	1	OPS	Danielle Campbell, MPH	UCLA/MLKCH	July 1, 2019	June 30, 2021	
38	Representative, Board Office 3	1	EXC|PP|SBP	Katja Nelson, MPP	APLA	July 1, 2018	June 30, 2022	
39	Representative, Board Office 4	1	SBP	Justin Valero, MA	Unaffiliated Consumer	July 1, 2019	June 30, 2021	
40	Representative, Board Office 5	1	PP&A|EXC	Raquel Cataldo	Tarzana Treatment Center	July 1, 2018	June 30, 2022	
41	Representative, HOPWA	1	PP&A	Maribel Ulloa	City of Los Angeles, HOPWA	July 1, 2019	June 30, 2021	
42	Behavioral/social scientist	1	EXC|PP	Lee Kochems	*Unaffiliated Consumer*	July 1, 2018	June 30, 2022	
43	Local health/hospital planning agency representative			*Vacant*		July 1, 2019	June 30, 2021	
44	HIV stakeholder representative #1	1	EXC	Grissel Granados, MSW	Children's Hospital Los Angeles	July 1, 2018	June 30, 2022	
45	HIV stakeholder representative #2	1	SBP	Paul Nash, CPsychol AFBPsS FHEA	University of Southern California	July 1, 2019	June 30, 2021	
46	HIV stakeholder representative #3	1	EXC|OPS	Juan Preciado	Northeast Valley Health Corporation	July 1, 2018	June 30, 2022	
47	HIV stakeholder representative #4			*Vacant*		July 1, 2019	June 30, 2021	
48	HIV stakeholder representative #5			*Vacant*		July 1, 2018	June 30, 2022	
49	HIV stakeholder representative #6	1	SBP	Amiya Wilson	Unaffiliated Consumer	July 1, 2019	June 30, 2021	
50	HIV stakeholder representative #7	1	PP&A	William D. King, MD, JD, AAHIVS	W. King Health Care Group	July 1, 2018	June 30, 2022	
51	HIV stakeholder representative #8			*Vacant*		July 1, 2018	June 30, 2022	Miguel Alvarez (OPS/SBP)
	TOTAL:	**35**						

LEGEND: EXC=EXECUTIVE COMM | OPS=OPERATIONS COMM | PP&A=PLANNING, PRIORITIES & ALLOCATIONS COMM | PPC=PUBLIC POLICY COMM | SBP=STANDARDS & BEST PRACTICES COMM

LOA: Leave of Absence

and it can be mailed, e-mailed or picked up at the office. Similarly, the application and is available online from the Commission's website at http://hiv.lacounty.gov. Submit your application by mailing it to or dropping it off at: 3530 Wilshire Blvd, Suite 1140, Los Angeles, CA 90010.
Applications may be emailed to hivcomm@lachiv.org. Staff will verify receipt of all applications via email. After receiving the application, staff will review it for accuracy and completeness, and contact the applicant if there are any possible errors, sections needing clarification, and/or if there are any questions that emerge from the application. Once the application has been deemed to be "complete" (either after revisions have been made, if necessary, or none are needed), staff will contact the applicants to schedule an interview with members of the Operations Committee. If you have questions or need assistance with the application, please contact the Commission office at (213) 738-2816.

PART II: MEMBERSHIP APPLICATION FORM
Section 1: Contact Information

1. Name: Luckie Alexander Fuller
   (Please print name as you would like it to appear in communications)
2. Organization: (if applicable) Invinsible Men
3. Job Title: Founder
4. Mailing Address: 3501 S La Brea Ave #108
5. City: Los Angeles State: CA Zip Code: 90016
6. Provide address of office and where services are provided (if different from above):
   Mailing Address: ______
   City: ______ State: ______ Zip Code: ______

7. Tel.: 2135280482 Fax: ______
8. Email: luckiealexander@invisibletmen.com
   (Most Commission communications are conducted through email)
9. Mobile Phone #: (optional): ______

My signature below indicates that I will make every effort to attend all of the meetings and activities of the Commission, the committee to which I am assigned and related caucuses, task forces and working groups that I have joined voluntarily or that I have been asked to support. I will comply with the Commission's expectations, rules and regulations, conflict of interest guidelines and its code of conduct, consistent with all relevant policies and procedures. As the undersigned, I understand that governing legislation and/or guidance may be altered in the future, necessitating revision, modification, or elimination of specific Commission processes or practices—necessitating change with which I will be expected to comply as well. I further understand that sections of this application will be distributed publicly, as required by the Commission's Open Nominations Process and consistent with California's Ralph M. Brown Act. I affirm that the information herein is accurate to the best of my knowledge.

Signature: ______ Date: ______

Print Name: ______

Section 2: Demographic Information

1. **Can you commit to the Commission's minimum expectations of active participation, regular attendance and sustained involvement?** ☐ **Yes** ☐ **No**

2. **In which Supervisorial District and SPA do you work?** Check all that apply.

District 1	❑	SPA 1	❑	SPA 5	❑
District 2	❑	SPA 2	❑	SPA 6	❑
District 3	❑	SPA 3	❑	SPA 7	❑
District 4	❑	SPA 4	❑	SPA 8	❑
District 5	❑				

3. **In which Supervisorial District and SPA do you live?**

District 1	❑	SPA 1	❑	SPA 5	❑
District 2	❑	SPA 2	❑	SPA 6	❑
District 3	❑	SPA 3	❑	SPA 7	❑
District 4	❑	SPA 4	❑	SPA 8	❑
District 5	❑				

4. **In which Supervisorial District and SPA do you receive HIV (care or prevention) services?** Check all that apply.

District 1	❑	SPA 1	❑	SPA 5	❑
District 2	❑	SPA 2	❑	SPA 6	❑
District 3	❑	SPA 3	❑	SPA 7	❑
District 4	❑	SPA 4	❑	SPA 8	❑
District 5	❑				

5. **Demographic Reflectiveness and Representation:**
Federal funders require that the Commission report the following demographic information annually to ensure its conformity with reflection/representation rules.

5a. **Gender:** ❑ Male ❑ Female ❑ Trans (Male to Female) ❑ Trans (Female to Male) ❑ Unknown

5b. **Race/Ethnicity:** (Check all that apply)

❑ African- American/Black,not Hispanic
❑ American Indian/Alaska Native
❑ Anglo/White, not Hispanic
❑ Asian/ Pacific Islander
❑ Hispanic
❑ Multi-Race
❑ Other :_______________
❑ Decline to State/Not Specified

5c. **Are you a parent/guardian/direct caregiver to a child with HIV under 19?** ❑ Yes ❑ No

6. **FOR APPLICANTS LIVING WITH HIV:**

6a. **Are you willing to publicly disclose your HIV status?** ❑ Yes* ❑ No
***DO NOT CHECK YES HERE if you do not want your HIV status known publicly. There is NO requirement that someone with HIV must disclose his/her status to the Commission or publicly.**

6b. **Age:**
❑ 13 – 19 years old ❑ 20 – 29 years old
❑ 30 – 39 years old ❑ 40 – 49 years old ❑ 50-59 years old
❑ 60+ years old ❑ Unknown

6c. **Are you a "consumer" (patient/client) of Ryan White Part A services?** ❑ Yes ❑ No

6d. **Are you "affiliated" with a Ryan White Part A-funded agency?** ❑ Yes ❑ No

By indicating "affiliated," you are a: ❑ board member, ❑ employee, or ❑ consultant at the agency. A volunteer at an agency is considered an unaffiliated consumer.

Section 3: Experience/Knowledge

7. **Recommending Entities/Constituency(ies):** "Recommending Entities" are the individuals/ organizations who may have suggested or asked you to represent them on the Commission.

7a. **What organization/Who, if any/anyone, recommended you to the Commission?**

____

7b. **If recommended, what seat, if any, did he/she/they recommend you fill?**

____

8. **Please check all of the boxes that apply to you:**

1 ❑ I am willing to publicly disclose that I have Hepatitis B or C.
2 ❑ I am an HIV-negative user of HIV prevention services and who is a member of an identified high-risk, special or highly impacted population.
3 ❑ I am a member of a federally-recognized American Indian tribe or Native Alaskan village.
4 ❑ I am a behavioral or social scientist who is active in research from my respective field.
5 ❑ I am involved in HIV-related research in the following capacity(ies) (Check all that apply):
❑ scientist, lead researcher or PI, ❑ staff member, ❑ study participant, or ❑ IRB member.
6 ❑ A health or hospital planning agency has recommended that I fill that seat on the Commission.
7 ❑ I am an HIV specialty physician or an Infectious Disease (ID) doctor with HIV- positive patients.
8 ❑ The agency where I am employed provides mental health services.
9 ❑ The agency where I am employed provides substance abuse services.
10 ❑ The agency where I am employed is a provider of HIV care/treatment services.
11 ❑ The agency where I am employed is a provider of HIV prevention services.
12 ❑ The agency where I am employed is provider of ❑ housing and/or ❑ homeless services.
13 ❑ The agency where I am employed has HIV programs funded by Federal sources (other than Ryan White).
14 ❑ I work for or am otherwise affiliated with a health care provider that is a Federally Qualified Health Center (FQHC) or a Community Health Clinic (CHC).
15 ❑ As someone who is employed as an advocate for incarcerated PWLH and/or as a PWLH who has been incarcerated in the past three years, I can represent the interests of incarcerated PWLH.
16 ❑ I am able to represent the interests of Ryan White Part C grantees.
17 ❑ I am able to represent the interests of Ryan White Part D grantees.
18 ❑ I am able to represent the interests of Ryan White Part F grantees given my affiliation with:
❑ one of LA County's AETC grantees/sub-grantees ❑ a HRSA SPNS grantee
❑ Part F dental reimbursement provider ❑ HRSA-contracted TA vendor
19 ❑ As an HIV community stakeholder, I have experience and knowledge given my affiliation with:
(Check all that apply)
❑ union or labor interests
❑ provider of employment or training services
❑ faith-based entity providing HIV services
❑ organization providing harm reduction services
❑ an organization engaged in HIV-related research
❑ the business community
❑ local elementary-/secondary-level education agency
❑ youth-serving agency, or as a youth.

9. **Training Requirements:** The Commission requires all members to complete the following trainings, which can be fulfilled if the trainings were provided by other institutions. Applicants will not be penalized for no prior training, but must take it once appointed.

9a. **Have you completed an "Introduction to HIV/STI,""HIV/STI 101," or a related basic informational HIV/STI training before? (If so, include Certificate of Completion; if not, the Commission provides the training)** ❑ Yes ❑ No

9b. **Have you completed a Health Insurance Portability and Accountability Act (HIPAA) training before?** (If so, please include Certificate of Completion; if not, the Commission will provide the training) ❑ Yes ❑ No

9c. **Have you completed a "Protection of Human Research Subjects" training before?** (If so, please include Certificate of Completion; if not, the Commission will provide the training) ❑ Yes ❑ No

Section 4: Biographical Information

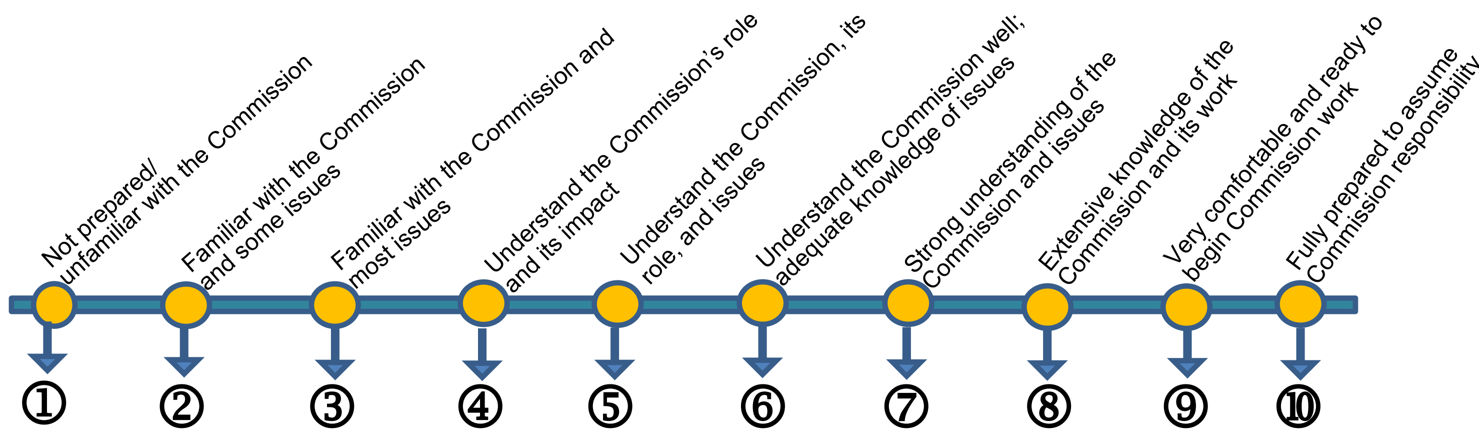
10. **Personal Statement:** The "personal statement" is a snapshot of your goals of your Commission participation, against which you can measure your effectiveness as a Commission member. This statement may be included on the Commission's website in the member section. Provide a short (50-word maximum) statement expressing why you want to be a Commission member:

11. **Biography/Resume**: If you would like, you can indicate below that you are updating this section from your original or renewal application, or simply write a new paragraph. You may—but it is not required—attach a new/updated resume. You may continue on an additional page, if necessary. As you feel appropriate, please provide a short biography detailing your background, and how it has prepared you for service on the Commission:

12. **Additional Information**: In this section, please provide any additional information about yourself—or update information from your original or renewal application—that you feel will enhance the application review. If you choose not to include any additional information, indicate it here with "N/A". Your additional information may continue on an additional page, if necessary:

Section 5: New Member Applicant (Only to be completed by new member applicant)

13. **How prepared do you feel you are to serve as a member of the Commission, if appointed?** A candidate's "preparedness" for Commission service is assessed—for this response—according to the 10-point scale located on the next page, which indicates that those who are the "least" prepared ("1" on the scale) are "not familiar" with the Commission and the issues that it reviews. The more prepared a candidate is—as indicated on the scale (moving towards "10" from "1")—s/he should demonstrate increased familiarity with the Commission and its content, evolving into "understanding" and "comfort" with the role of the Commission and its practices, and "limited" to "extensive" knowledge about the topics it addresses. Mark the circle that represents where you feel you fall on this scale of "preparedness" ("1" is "not prepared" ➡ "10," "fully prepared")



14. **Describe any personal/professional experience that you believe has prepared you to perform effectively as a member of the Commission. Continue on an additional page if necessary.**

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15. **What do you anticipate your greatest hurdles will be acclimating to your new role on the Commission? How do you think you will overcome them? Continue on an additional page if necessary.**

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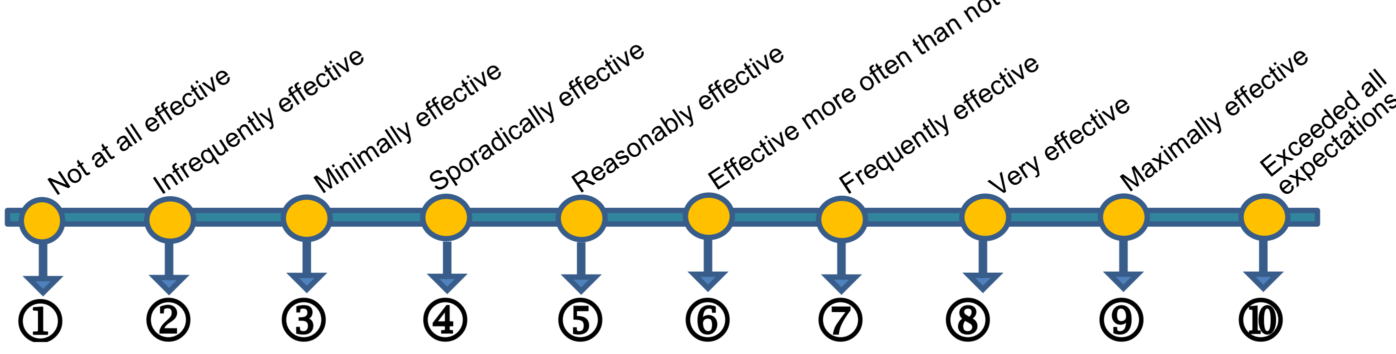
16. **How will your Commission membership benefit the lives of LA County residents with HIV/STDs and/or who are at high-risk of HIV-/STD-infection? Continue on an additional page if necessary.**

17. **Which of your strengths do you feel will enhance your Commission performance? What skills will you need to develop further for optimal Commission performance? Continue on an additional page if necessary.**

18. **Candidates are also nominated to fill Alternate seats as well: if you were nominated for an Alternate seat, would you be willing to serve in that capacity?** ❑ Yes ❑ No

Section 6: Renewal Applicant (Only to be completed by renewal applicant)

19. **How effective do you feel you were during your most recent term on the Commission?** Mark the circle that you feel is the best assessment of your Commission participation and engagement in the last term (1 is least effective ➡ 10 is most effective)



20. **Explain why you rated yourself the way you did in Question #16. Continue on an additional page, if necessary.**

21. **In your last term, what would you have done differently and what would you have improved, if anything (e.g., quality, communication skills, participation)?** Continue on an additional page, if necessary..

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22. **In your last term, what, if any, barriers and/or obstacles prevented you from fully carrying out your Commission responsibilities as you would have liked?** Continue on an additional page, if necessary.

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23. **What can the Commission do to help improve your effectiveness and/or level of contribution/accomplishment in your next term?** Continue on an additional page, if necessary.

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24. **Candidates are also nominated to fill Alternate seats as well: if you were nominated for an Alternate seat, would you be willing to serve in that capacity?**

ALEXANDER E. L. FULLER

(213) 528.0482 / LuckieAlexander@InvisibleTMen.com

Qualifications

- *Project Planning and Implementation*
- *Public Speaking & Facilitation*
- *Network Creation & Resolution*
- *Hardware Repair & Upgrade*
- *Technical Resolution & Support*
- *Leadership Training*
- *Community Outreach*
- *Volunteer Recruitment & Training*
- *Special Events Management*
- *Social & Gender Justice Advocate*
- *HIV/AIDS Advocate*

Education

Community College So. NV High School
High School Diploma GPA 3.8
AA Degree: Culinary Arts
Clearfield Job Corps. Center
Certificate: Level II Technician
Certificate: Jr. Welder
L.A. Trade Technical Comm. College
AS Degree: Computer Information Systems
AS: Degree Mathematics
Certificate: Web Design & MicroComputer Technician
Member: Alpha Omega Nu Fraternity / Brown Boi Project Historian

PERSONAL COMPUTER SKILLS

Microsoft Word | Microsoft Excel | Microsoft Access
Microsoft PowerPoint | Microsoft Publisher | Microsoft Outlook
Adobe Suite CS5.5 | Facebook | Network+

PROFILE

DYNAMIC, GOAL-ORIENTED MANAGEMENT PROFESSIONAL committed to quality and excellence in administrative, executive, and technical support. Strong contributions in managing a full scope of support operations in high-profile settings. Exceptional organizational skills highlight the ability to prioritize and process multiple projects and tasks concurrently; using focused detail monitoring, problem solving and follow-through procedures. Proficient arranging of all meeting logistics; taking into consideration strategic need in terms of selective requirements. Possess superb written communication, interpersonal and presentation skills. Utilize excellent computer skills involving website design, creating and maintaining spreadsheets, graphic design, hardware repair, upgrade and maintenance.

SELECTED ACCOMPLISHMENTS

- Led the creation of a Drug and Alcohol Free youth program on the campus of Clearfield Job Corps. Center
- Demonstrated leadership skills as a Captain in the Ranger Program, supervising and managing up to 75+ individuals on security detail during the Special Olympics in Salt Lake City, Utah
- Community advocacy within L. A. County with various organizations also currently doing policy and HIV work around Trans and GNC communities.
- Performed volunteer coordination and security detail at the 2013 Tuskegee Airmen Convention in St. Louis, Missouri
- Recognized by the Library of Congress for the creation of the National Trans Visibility March website
- Created inclusive “All Black Lives Matter” Mural on Hollywood Blvd

Alexander E. L. Fuller

Skills & Experience

IT Technician

▪ Repaired, upgraded and maintained company computers and equipment on and off-site as well gave technical support via phone and remote connection

▪ Setup and networked multiple workstations locally (LANs) and throughout company locations (WANs), monitored network connections for efficiency, resolve network connectivity issues

Management

▪ Participated in monthly organization conference calls then transmitted updated organization information and statistics to the executive team via secondary meetings, correspondence and spreadsheets that fostered a well-informed, cohesive and collaborative group.

Communication

▪ Avoided time issue rectifications and / or missed fix opportunities by performing as a conduit to the leadership team by instituting method of real time communication utilizing technological aspects of text messaging, and Microsoft Outlook email when immediate notification is necessary.

▪ Orchestrated the creation of a streamlined process to monitor and classify incoming information gleaned from thorough research for the creation of agendas which resulted in elimination of overwhelming and redundant actions allowing timely distribution.

Strategic Planning

▪ Cultivated and created a step-by-step process and confirmation protocol while coordinating multiple people; travel, ground transportation, accommodations arrangements and meal requirements to prevent last minute negative incidents which enhanced my reputation for efficiency and clarity.

Community Outreach

▪ Utilized outstanding and exceptional personable skills and event planning knowledge to recruit community members to participate in fundraising efforts to aid various demographic groups
Completed HIV & AIDS education & Facilitating training with APAIT
Assisted with the strategy and execution of the 1st annual Trans Visibility March

■ Work History

Workforce Development Director - Trans Can Work, Los Angeles, Ca (2018 -2020)
Asst. Strategy Director - Nat'l Trans Visibility March, National / Washington DC (2018 -2019)
Cultural Humility Trainer - Community Partners, Los Angeles, CA (2017 - Current)
Founder – Invisible Men, Los Angeles, CA (2018 - Current)
Event Producer/ Volunteer Coordinator – Xtravaganza Upscale Event Planners & Consultants, Las Vegas, NV (1997 – 2013)
Homeless Housing Manager/Program Director – SSG, CMB, Los Angeles, Ca (2007-2013)

■ PROFESSIONAL AFFILIATIONS

- LGBTQ Peer Mentor / Counselor, Las Vegas LGBTQ Center (2002 - 2005)
- Production Coordinator , "Women of Entertainment, Fashion, Music and Media". (2002 - 2013)
- Anchor Member & Historian – Brown Boi Project (2010 - Present)
- Los Angeles County HIV Commissioner (2018 - 2019)
- Los Angeles City Trans Advisory Council Member (2017 - Present)
- CAB Member - UCLA CHIPTS (2018 - Present)

MITCH O'FARRELL
Councilmember
13th District

September 23, 2020

To Whom It May Concern:

I am writing to strongly recommend Luckie Alexander as an appointee to the Los Angeles County Commission on HIV. Since 2017, I have had the pleasure of working with Luckie in his role as Chair of the Los Angeles Transgender Advisory Council (TAC)'s Employment and Job Readiness Committee. As TAC Chair, he has worked with my office and various organizations in a number of ways, including producing the successful "Avenues to Success" job readiness fairs, which provide informational workshops and vital resources to the transgender and nonbinary communities. This dedication to the communities under the transgender umbrella shows Luckie's thoughtfulness and desire to collaborate effectively.

Earlier this year, as the country grappled with both a pandemic and the immediate aftermath of Goerge Floyd's murder, our City's queer communites also suffered the additional loss with the cancellation of the LA Pride Festival. Luckie, as a member of Black LGBTQ+ Activists for Change, met the moment and rose to the occasion to produce the "All Black Lives Matter" March, in which tens of thousands rallied for all queer Black lives in a peaceful protest on Hollywood Boulevard.

Leading up to this historic event, Luckie collaborated with my office and various City departments and local businesses to create a temporary two-block wide decorative street design with the message "All Black Lives Matter. Noting that erasure of the transgender community is very real, Luckie further collaborated with me to create a permanant decorative street design and the City's first ever street sign dedicated to transgender people of color.

Through these collaborations, Luckie has consistently shown his motivation toward achieving excellence while being respectful and perceptive of other points of view. This speaks to the trust that Luckie has built with the City, his colleagues on the TAC, and the queer and transgender communities at large. It has been my personal honor to witness the positive impacts that Luckie has made on his City and the communities that make it their home.

With his inherent sense of engagement, Luckie is a pleasure to work with. His passion and perspective, and his catalogue of knowledge and unique insight as a transmasculine Black man, have been an imperative ingredient in our common goal of providing unity in our City during uncertain and challenging times. I can say without reservation that I strongly recommend Luckie Alexander for as an appointee to the Los Angeles County Commission on HIV. Should you have any questions, please do not hesitate to contact me at Mitch.OFarrell@lacity.org or at (213) 473-7013.

Sincerely,

MITCH O'FARRELL

CITY HALL 200 N. Spring Street Room 480 Los Angeles CA 90012 OFFICE: 213.473.7013 FAX: 213.473.7734
DISTRICT OFFICE 1722 Sunset Boulevard Los Angeles, CA 90026 OFFICE: 213.207.3015 FAX: 213.207.3031
cd13.com

and it can be mailed, e-mailed or picked up at the office. Similarly, the application and is available online from the Commission's website at http://hiv.lacounty.gov. Submit your application by mailing it to or dropping it off at: 3530 Wilshire Blvd, Suite 1140, Los Angeles, CA 90010.
Applications may be emailed to hivcomm@lachiv.org. Staff will verify receipt of all applications via email. After receiving the application, staff will review it for accuracy and completeness, and contact the applicant if there are any possible errors, sections needing clarification, and/or if there are any questions that emerge from the application. Once the application has been deemed to be "complete" (either after revisions have been made, if necessary, or none are needed), staff will contact the applicants to schedule an interview with members of the Operations Committee. If you have questions or need assistance with the application, please contact the Commission office at (213) 738-2816.

PART II: MEMBERSHIP APPLICATION FORM
Section 1: Contact Information

1. Name: Ernest Walker
   (Please print name as you would like it to appear in communications)
2. Organization: (if applicable) Men's Health Foundation
3. Job Title: Director of SoCal Club
4. Mailing Address: 8601 S. Broadway
5. City: Los Angeles State: CA Zip Code: 90003
6. Provide address of office and where services are provided (if different from above):
   Mailing Address:
   City: State: Zip Code:

7. Tel.: (310) 550-1010 Fax:
8. Email: ernest.walker@menshealthfound.org
   (Most Commission communications are conducted through email)
9. Mobile Phone #: (optional): (404) 798-3357

My signature below indicates that I will make every effort to attend all of the meetings and activities of the Commission, the committee to which I am assigned and related caucuses, task forces and working groups that I have joined voluntarily or that I have been asked to support. I will comply with the Commission's expectations, rules and regulations, conflict of interest guidelines and its code of conduct, consistent with all relevant policies and procedures. As the undersigned, I understand that governing legislation and/or guidance may be altered in the future, necessitating revision, modification, or elimination of specific Commission processes or practices—necessitating change with which I will be expected to comply as well. I further understand that sections of this application will be distributed publicly, as required by the Commission's Open Nominations Process and consistent with California's Ralph M. Brown Act. I affirm that the information herein is accurate to the best of my knowledge.

Signature: 06/29/2020
Date

Ernest Walker
Print Name

Section 2: Demographic Information

1. **Can you commit to the Commission's minimum expectations of active participation, regular attendance and sustained involvement?** ☐ Yes ☐ No

2. **In which Supervisorial District and SPA do you work?** Check all that apply.

District 1	☐	SPA 1	☐	SPA 5	☐
District 2	☐	SPA 2	☐	SPA 6	■
District 3	☐	SPA 3	☐	SPA 7	☐
District 4	☐	SPA 4	☐	SPA 8	☐
District 5	☐				

3. **In which Supervisorial District and SPA do you live?**

District 1	☐	SPA 1	☐	SPA 5	☐
District 2	☐	SPA 2	☐	SPA 6	■
District 3	☐	SPA 3	☐	SPA 7	☐
District 4	☐	SPA 4	☐	SPA 8	☐
District 5	☐				

4. **In which Supervisorial District and SPA do you receive HIV (care or prevention) services?** Check all that apply.

District 1	☐	SPA 1	☐	SPA 5	☐
District 2	☐	SPA 2	☐	SPA 6	■
District 3	☐	SPA 3	☐	SPA 7	☐
District 4	☐	SPA 4	☐	SPA 8	☐
District 5	☐				

5. **Demographic Reflectiveness and Representation:**
Federal funders require that the Commission report the following demographic information annually to ensure its conformity with reflection/representation rules.

5a. **Gender:** ■ Male ☐ Female ☐ Trans (Male to Female) ☐ Trans (Female to Male) ☐ Unknown

5b. **Race/Ethnicity:** (Check all that apply)

■ African- American/Black,not Hispanic
☐ Hispanic
☐ American Indian/Alaska Native
☐ Multi-Race
☐ Anglo/White, not Hispanic
☐ Other :______________
☐ Asian/ Pacific Islander
☐ Decline to State/Not Specified

5c. **Are you a parent/guardian/direct caregiver to a child with HIV under 19?** ☐ Yes ■ No

6. **FOR APPLICANTS LIVING WITH HIV:**

6a. **Are you willing to publicly disclose your HIV status?** ■ Yes* ☐ No
***DO NOT CHECK YES HERE if you do not want your HIV status known publicly. There is NO requirement that someone with HIV must disclose his/her status to the Commission or publicly.**

6b. **Age:** ☐ 13 – 19 years old ☐ 20 – 29 years old ☐ 30 – 39 years old ■ 40 – 49 years old ☐ 50-59 years old ☐ 60+ years old ☐ Unknown

6c. **Are you a "consumer" (patient/client) of Ryan White Part A services?** ☐ Yes ■ No

6d. **Are you "affiliated" with a Ryan White Part A-funded agency?** ■ Yes ☐ No

By indicating "affiliated," you are a: ☐ board member, ■ employee, or ☐ consultant at the agency. A volunteer at an agency is considered an unaffiliated consumer.

Section 3: Experience/Knowledge

7. **Recommending Entities/Constituency(ies):** "Recommending Entities" are the individuals/ organizations who may have suggested or asked you to represent them on the Commission.

7a. **What organization/Who, if any/anyone, recommended you to the Commission?**

Men's Health Foundation / Dr. Tony Mills

7b. **If recommended, what seat, if any, did he/she/they recommend you fill?**

8. **Please check all of the boxes that apply to you:**

1 ☐ I am willing to publicly disclose that I have Hepatitis B or C.

2 ☐ I am an HIV-negative user of HIV prevention services and who is a member of an identified high-risk, special or highly impacted population.

3 ☐ I am a member of a federally-recognized American Indian tribe or Native Alaskan village.

4 ☐ I am a behavioral or social scientist who is active in research from my respective field.

5 ☐ I am involved in HIV-related research in the following capacity(ies) (Check all that apply):
☐ scientist, lead researcher or PI, ☐ staff member, ☐ study participant, or ☐ IRB member.

6 ☐ A health or hospital planning agency has recommended that I fill that seat on the Commission.

7 ☐ I am an HIV specialty physician or an Infectious Disease (ID) doctor with HIV- positive patients.

8 ☐ The agency where I am employed provides mental health services.

9 ☐ The agency where I am employed provides substance abuse services.

10 ■ The agency where I am employed is a provider of HIV care/treatment services.

11 ■ The agency where I am employed is a provider of HIV prevention services.

12 ☐ The agency where I am employed is provider of ☐ housing and/or ☐ homeless services.

13 ■ The agency where I am employed has HIV programs funded by Federal sources (other than Ryan White).

14 ☐ I work for or am otherwise affiliated with a health care provider that is a Federally Qualified Health Center (FQHC) or a Community Health Clinic (CHC).

15 ☐ As someone who is employed as an advocate for incarcerated PWLH and/or as a PWLH who has been incarcerated in the past three years, I can represent the interests of incarcerated PWLH.

16 ☐ I am able to represent the interests of Ryan White Part C grantees.

17 ☐ I am able to represent the interests of Ryan White Part D grantees.

18 ☐ I am able to represent the interests of Ryan White Part F grantees given my affiliation with:
☐ one of LA County's AETC grantees/sub-grantees ☐ a HRSA SPNS grantee
☐ Part F dental reimbursement provider ☐ HRSA-contracted TA vendor

19 ☐ As an HIV community stakeholder, I have experience and knowledge given my affiliation with:
(Check all that apply)

☐ union or labor interests
☐ provider of employment or training services
☐ faith-based entity providing HIV services
■ organization providing harm reduction services
■ an organization engaged in HIV-related research
☐ the business community
☐ local elementary-/secondary-level education agency
■ youth-serving agency, or as a youth.

9. **Training Requirements:** The Commission requires all members to complete the following trainings, which can be fulfilled if the trainings were provided by other institutions. Applicants will not be penalized for no prior training, but must take it once appointed.

9a. **Have you completed an "Introduction to HIV/STI,""HIV/STI 101," or a related basic informational HIV/STI training before? (If so, include Certificate of Completion; if not, the Commission provides the training)** ☐ Yes ■ No

9b. **Have you completed a Health Insurance Portability and Accountability Act (HIPAA) training before?** (If so, please include Certificate of Completion; if not, the Commission will provide the training) ■ Yes ☐ No

9c. **Have you completed a "Protection of Human Research Subjects" training before?** (If so, please include Certificate of Completion; if not, the Commission will provide the training) ☐ Yes ☐ No

Section 4: Biographical Information

10. **Personal Statement:** The "personal statement" is a snapshot of your goals of your Commission participation, against which you can measure your effectiveness as a Commission member. This statement may be included on the Commission's website in the member section. Provide a short (50-word maximum) statement expressing why you want to be a Commission member:

Having provided over 25 years of HIV Prevention and Ryan White services and have sat on the HIV Prevention and the Ryan White council in Washington DC and in Atlanta GA. I believe I have the experience and the knowledge to help support and drive the agenda that is set forth of the Commission. To provide meaningful prevention and supportive services to LA county.

11. **Biography/Resume:** If you would like, you can indicate below that you are updating this section from your original or renewal application, or simply write a new paragraph. You may—but it is not required—attach a new/updated resume. You may continue on an additional page, if necessary. As you feel appropriate, please provide a short biography detailing your background, and how it has prepared you for service on the Commission:

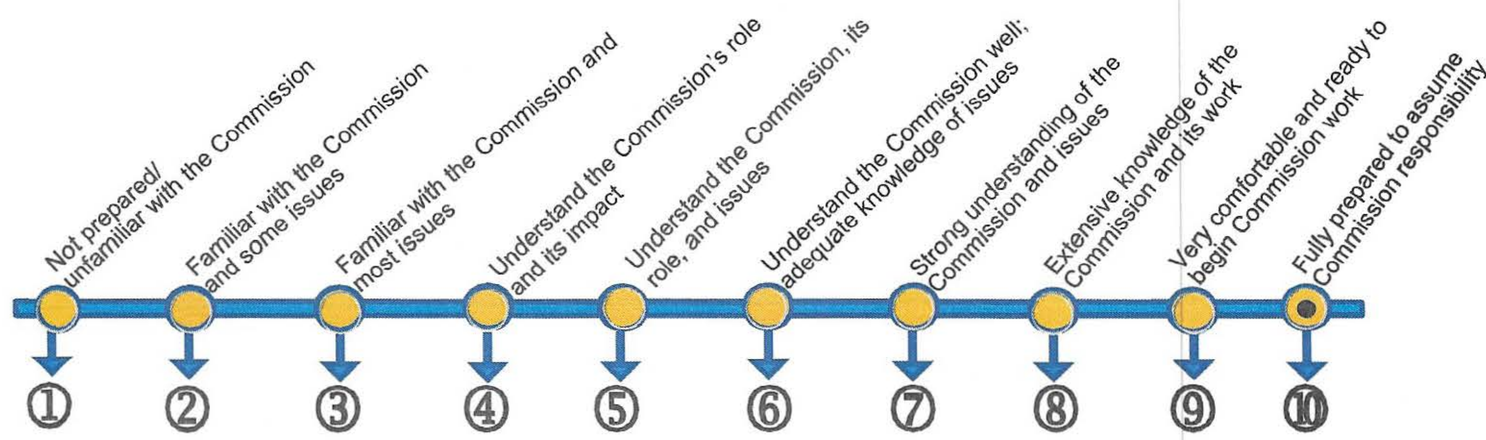
See Resume attached

12. **Additional Information**: In this section, please provide any additional information about yourself—or update information from your original or renewal application—that you feel will enhance the application review. If you choose not to include any additional information, indicate it here with "N/A". Your additional information may continue on an additional page, if necessary:

N/A

Section 5: New Member Applicant (Only to be completed by new member applicant)

13. **How prepared do you feel you are to serve as a member of the Commission, if appointed?** A candidate's "preparedness" for Commission service is assessed—for this response—according to the 10-point scale located on the next page, which indicates that those who are the "least" prepared ("1" on the scale) are "not familiar" with the Commission and the issues that it reviews. The more prepared a candidate is—as indicated on the scale (moving towards "10" from "1")—s/he should demonstrate increased familiarity with the Commission and its content, evolving into "understanding" and "comfort" with the role of the Commission and its practices, and "limited" to "extensive" knowledge about the topics it addresses. Mark the circle that represents where you feel you fall on this scale of "preparedness" ("1" is "not prepared" ➡ "10," "fully prepared")



14. **Describe any personal/professional experience that you believe has prepared you to perform effectively as a member of the Commission. Continue on an additional page if necessary.**

I have been a co-chair of the DC HIV Prevention Planning Council and was a voting member of DC Ryan White Planning. I served on both of these councils for over 10 years. I understand and can help write policies and procedures. I have experience in understanding and explaining epi data. I also ran a couple of nonprofits and understand budgeting and audits.

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15. **What do you anticipate your greatest hurdles will be acclimating to your new role on the Commission? How do you think you will overcome them? Continue on an additional page if necessary.**

I believe my greatest challenge would be is coming onto the commission as an outsider and the clashing of ideas that individuals who have strong personalities that dismiss new ideas and new or different thought processes.

I would over come by listening first and formost and find the common denominator and work from there. However, when it is all said and done the end result will always be about the consumers needs. We can agree to disagree and I will always work for the consumers needs to be met to the best of our ability as a commission member.

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16. **How will your Commission membership benefit the lives of LA County residents with HIV/STDs and/or who are at high-risk of HIV-/STD-infection? Continue on an additional page if necessary.**

I started my work in HIV/STD managing outreach and community engagement. Listeing to the community needs, attending community events and supporting community partnerships. I bring a fresh mind and innovative ideas that could help in the commissions agenda to help address the community disparities. HIV Prevention and Treament has been my life work for over 20 years.

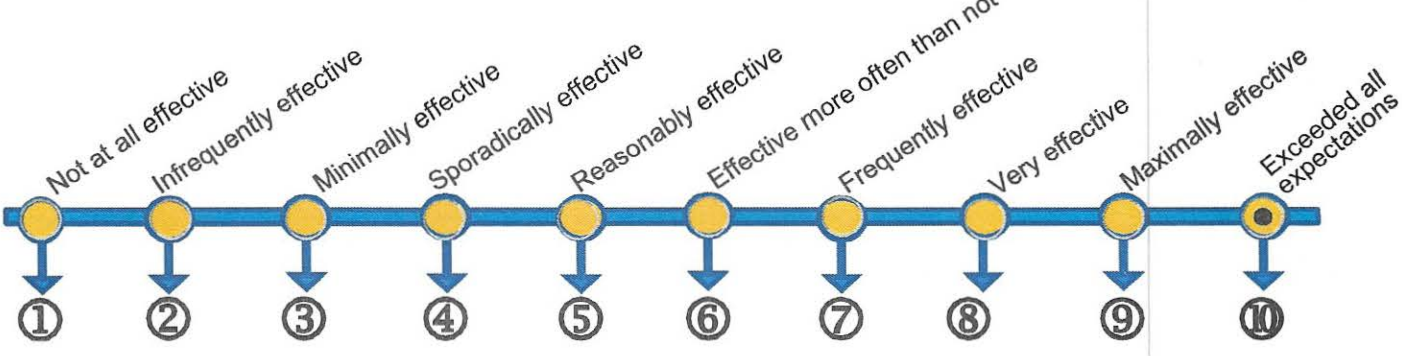
17. **Which of your strengths do you feel will enhance your Commission performance? What skills will you need to develop further for optimal Commission performance? Continue on an additional page if necessary.**

I believe I have the skills needed to be a thriving member of the commission.

18. **Candidates are also nominated to fill Alternate seats as well: if you were nominated for an Alternate seat, would you be willing to serve in that capacity?** ☒ Yes ☐ No

Section 6: Renewal Applicant (Only to be completed by renewal applicant)

19. **How effective do you feel you were during your most recent term on the Commission?** Mark the circle that you feel is the best assessment of your Commission participation and engagement in the last term (1 is least effective ➡ 10 is most effective)



20. **Explain why you rated yourself the way you did in Question #16. Continue on an additional page, if necessary.**

I have over 10 years of being on planning councils and have chaired many committees. I have a MPH. I know how to trouble shoot and execute approved plans. I am a motivater , a leader and a team player. I know how to facilitate community engagement and assign duties and tasks.

21. **In your last term, what would you have done differently and what would you have improved, if anything (e.g., quality, communication skills, participation)?** Continue on an additional page, if necessary..

22. **In your last term, what, if any, barriers and/or obstacles prevented you from fully carrying out your Commission responsibilities as you would have liked?** Continue on an additional page, if necessary.

23. **What can the Commission do to help improve your effectiveness and/or level of contribution/accomplishment in your next term?** Continue on an additional page, if necessary.

24. **Candidates are also nominated to fill Alternate seats as well: if you were nominated for an Alternate seat, would you be willing to serve in that capacity?**

Ernest.Walk3r@gmail.com
404.798.3357

ERNEST WALKER

SENIOR EXECUTIVE SUMMARY

An accomplished senior-level executive with a 15-year track record in progressive policy development, financial and program management, advocacy and coalition building. A professional journey from community health advocate to an executive officer has offered a unique and passionate understanding of community needs and disparities and makes a valuable asset to your mission-driven, health and human services organization. Core competencies include:

- Vision, mission & strategic planning
- Policy & procedure development
- Government relations/grant writing/contract negotiation
- Team building expertise

AREAS OF EXPERTISE

- Team Building & Leadership
- Multilateral Institutions & Strategic Planning
- Inter-agency Collaboration and Organizational experience
- Strategic Messaging and Management of Budgets (Planning and Grants)
- Development and Fundraising
- Program Development and Management
- Communication/Public Engagement
- Public Relations Coalition-Building/Issue Campaigns

PROFESSIONAL EXPERIENCE

CO-EXECUTIVE DIRECTOR ❖ LOST-N-FOUND YOUTH

November 2018 – Present

One half of a two prong leadership that I share in running the day to day operations of the entire agency and report directly to the board of directors. Key responsibilities include design and implementation of all agency programs, as well as outreach and recruitment. A focus on the visibility and sustainability of the agency, with an additional responsibility for overseeing the day-to-day program operations. Responsible for raising revenue to support two core programs at the Drop-n-Center and the transitional housing program.

- Raised $250,000 in the first 6 months to increase programs at the Drop-n-Center

- Developed and implemented new policies and procedures for the center and the transitional housing program

EXECUTIVE DIRECTOR (INTERIM)
❖ NAESM, INC.
March 2018 – September 2018

Served as interim ED with a focus on assessing the complex challenges around service delivery in the Atlanta metropolitan area given the transportation, housing, stigma, geographic/cultural issues, organizational trauma impacting the priority population. Delivered key recommendations to Board of Directors for successfully building and rebuilding partnerships and relationships with funders as well as establishing and growing new alignments with community and service boundary partners to help mitigate these complex and far reaching challenges. Responsible for overseeing all day to day operations of HIV/AIDS service organization that supports around 2,500 youth per year focusing on providing education, prevention, treatment, and supportive services for individuals impacted or at risk for HIV and other STIs. Key responsibilities included managing all staff, policies, procedures, and programs across 3 facilities.

- Managed a budget of 1.5 million, which includes $700,000 revenue directly raised within the 6th month position for program and agency expansion
- Successfully implemented new updated organizational policies and procedures
- Created and implemented agency-wide evaluation tool to assess staff on knowledge, performance, and service delivery at each job level
- Created and delivered strategy for strengthening the agency's brand and customer experience across technology platforms and points of service delivery
- Established a successful community engagement program to increase visibility and active participation among the community
- Secured sponsorship for agency national conference

CHIEF OPERATING OFFICER
❖ US HELPING US, PEOPLE INTO LIVING, INC.

Critically responsible for development and updating of the strategic plan as well as overall management of the agency, ensuring the agency remained adherent to the strategic plan. Advised the Chief Executive Officer and senior management on programmatic and financial planning, budgeting, cash flow and policy matters. Served as liaison between the Board of Directors and agency. Represented agency as both member and co-chair of Ryan White Planning Council where I was tasked to know and

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September 2014 – November 2017

explain funding prioritizations, supporting data, and budgets along with the need for continued RW funding to the full Ryan White council including the Mayor and public audiences at the numerous community forums. Used local and national epidemiology data to inform and to make informed decisions for program activities. Identified programs based on evidence-based interventions. Performed evaluations on activities, programs, and departments that improve policies and strengthen performance outcomes.

- Oversaw an operating budget of $3.1 million
- Successfully implemented evidenced based programming that garnered recognition as a leading peer organization; began supporting peer agency capacity building.
- Requested by the Mayor to conduct community health assessment and to create a plan to reduce the spread of HIV in DC by 2020 in accordance with the "90/90/90/50 plan".
- Promoted a culture of high performance and continuous improvement that values learning and commitment to quality
- Ensured staff members receive timely and appropriate training and development

DIRECTOR OF PROGRAMS

❖ US HELPING US, PEOPLE INTO LIVING, INC.

November 2012 - September 2015

Responsible for the oversight of all prevention and clinical programs as well as creation and implementation of new programs. Responsible for planning and execution of agency fundraising events. Managed HIV prevention and support program staff along with specific projects consultants, including group level, community, outreach and HIV/STI counseling and testing programs. Represented agency as both member and co-chair of Ryan White Planning Council where I was tasked to know and explain funding prioritizations, supporting data, and budgets along with the need for continued RW funding to the full Ryan White council including the Mayor and public audiences at the numerous community forums.

- Completed UCLA/Johnson & Johnson Healthcare Executive Program for senior level staff from Non-profits, clinics and federal qualified health centers in 2014; certification focused on using data to inform partners and stakeholders on the state of the HIV epidemic and some potential solutions from an agency perspective.
- Secured a 5 year CDC grant totaling 1.5 Million dollars
- Managed SAMSA grant of $650,000 for substance abuse and mental health services

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- Maintained attention to deliverables, deadlines and monthly report to CEO, funders and the board
- Ensured compliance with all federal and government regulations

MANAGER, OUTREACH/ VOLUNTEER SERVICES
❖ US HELPING US, PEOPLE INTO LIVING, INC.
January 2003 – November 2012

Managed calendars, scheduling meetings and assisting with budgets for agency program staff and program consultants. Assisted agency with office operations, to include administrative and technical duties. Responsible for design and development of training material and supporting resources based on identified needs. Developed training curriculum, agendas and resource material for outreach and volunteers. Maintained attention to deliverables, deadlines and submitting monthly reports.

- Completed the CDC, University of Las Vegas and University of South Carolina HIV Prevention Leadership Institute in 2007, learning to interpret epi data, complete needs assessment, program design and implementation, determining and locating community stakeholders and how to disseminate information back to community.
- Created a volunteer program for 850 volunteer's curriculum and training materials
- Key contributor to grant writing team that secured a 5 year CDC High Impact Prevention grant totaling $1.7 million dollars for a drop in center for youth

MANAGER, PREVENTION PROGRAMS
❖ MINORITY AIDS PROJECT
January 2000 – December 2002

Managed HIV prevention/support program staff and specific projects consultants, including group level, community, outreach and HIV/STI counseling and testing with an operating budget of $2 million. Maintained attention to deliverables, quality assurance, deadlines and monthly reporting for federal, local and private grantors including the Center for Disease Control, HIV AIDS Administration (Prevention and Ryan White), Washington AIDS Partnership, and Public Welfare Foundation. Represented agency at external venues; including the local community planning group, providing informational presentations to various agencies, organizations and conferences.

Responsible for staff training and development. Designated as lead agent in the absence of President/CEO. Provide direct services, as needed, including group facilitation, HIV testing/counseling and outreach coordination. Update Executive Board on progress towards programmatic goals and objections on quarterly basis. Member of local HIV prevention planning group (HPPG).

Ernest.Walk3r@gmail.com
404.798.3357

PROGRAM COORDINATOR ❖ PEOPLE OF COLOR AGAINST AIDS NETWORK February 1997 – December 1999	Managed calendars, scheduling meetings and assist with budgets for agency program staff and program consultants. Assisted the agency with office operations, which includes answering phones, sorting mail, and monthly calendar. Responsible for design and development of training material and supporting resources based on identified needs. Developed training curriculum, agendas and resource material for outreach. Maintain attention to deliverables, deadlines and submitting monthly reports.

PROFESSIONAL ACCOMPLISHMENTS

- CDC Leadership Institute – Atlanta, Georgia – Completed 2007
- Master Trainer Certification for CDC on Evidence Based Interventions – Completed 2009
- UCLA/Johnson & Johnson Executive Leadership Program – Los Angeles California – Completed 2014

KEY PRESENTATIONS

- Presentation: Workshop on "HIV in Black America" at 2010 Congressional Black Conference
- Presentation: "PrEP the blue pills" at the 2015 United States Conference on AIDS

AFFILIATIONS / MEMBERSHIPS

Board Chair of Brother to Brother in Seattle Washington 1998 - 2000

District of Columbia HIV Prevention Planning Group 2003 – 2008

District of Columbia Ryan White Planning Council 2012 – 2016

District of Columbia Ryan White Planning Council Co-chair 2014 - 2016

Current Board member of Southern AIDS Coalition since November 2016

Current Board member of ReJoyce Academy since January 2017

EDUCATION

Garfield High School —Seattle, Washington - 1989

University of Washington – Seattle, Washington – BS- CIVIL ENGINEERING -1995

Catholic University – Washington, District of Columbia – MPH - 2012

and it can be mailed, e-mailed or picked up at the office. Similarly, the application and is available online from the Commission's website at http://hiv.lacounty.gov. Submit your application by mailing it to or dropping it off at: 3530 Wilshire Blvd, Suite 1140, Los Angeles, CA 90010.
Applications may be emailed to hivcomm@lachiv.org. Staff will verify receipt of all applications via email. After receiving the application, staff will review it for accuracy and completeness, and contact the applicant if there are any possible errors, sections needing clarification, and/or if there are any questions that emerge from the application. Once the application has been deemed to be "complete" (either after revisions have been made, if necessary, or none are needed), staff will contact the applicants to schedule an interview with members of the Operations Committee. If you have questions or need assistance with the application, please contact the Commission office at (213) 738-2816.

PART II: MEMBERSHIP APPLICATION FORM
Section 1: Contact Information

1. Name: ______________________
   (Please print name as you would like it to appear in communications)
2. Organization: ______________________
   (if applicable)
3. Job Title: ______________________
4. Mailing Address: ______________________
5. City: ____________ State: ____________ Zip Code: ____________
6. Provide address of office and where services are provided (if different from above):
   Mailing Address: ______________________
   City: ____________ State: ____________ Zip Code: ____________

---

7. Tel.: "ON FILE" Fax: ____________
8. Email: ______________________
   (Most Commission communications are conducted through email)
9. Mobile Phone #: ______________________
   (optional):

My signature below indicates that I will make every effort to attend all of the meetings and activities of the Commission, the committee to which I am assigned and related caucuses, task forces and working groups that I have joined voluntarily or that I have been asked to support. I will comply with the Commission's expectations, rules and regulations, conflict of interest guidelines and its code of conduct, consistent with all relevant policies and procedures. As the undersigned, I understand that governing legislation and/or guidance may be altered in the future, necessitating revision, modification, or elimination of specific Commission processes or practices—necessitating change with which I will be expected to comply as well. I further understand that sections of this application will be distributed publicly, as required by the Commission's Open Nominations Process and consistent with California's Ralph M. Brown Act. I affirm that the information herein is accurate to the best of my knowledge.

Signature: ______________________ ____________ Date

____
Print Name

Section 2: Demographic Information

1. **Can you commit to the Commission's minimum expectations of active participation, regular attendance and sustained involvement?** ☐ **Yes** ☐ **No**

2. **In which Supervisorial District and SPA do you work?** Check all that apply.

District 1	❑	SPA 1	❑	SPA 5	❑
District 2	❑	SPA 2	❑	SPA 6	❑
District 3	❑	SPA 3	❑	SPA 7	❑
District 4	❑	SPA 4	❑	SPA 8	❑
District 5	❑				

3. **In which Supervisorial District and SPA do you live?**

District 1	❑	SPA 1	❑	SPA 5	❑
District 2	❑	SPA 2	❑	SPA 6	❑
District 3	❑	SPA 3	❑	SPA 7	❑
District 4	❑	SPA 4	❑	SPA 8	❑
District 5	❑				

4. **In which Supervisorial District and SPA do you receive HIV (care or prevention) services?** Check all that apply.

District 1	❑	SPA 1	❑	SPA 5	❑
District 2	❑	SPA 2	❑	SPA 6	❑
District 3	❑	SPA 3	❑	SPA 7	❑
District 4	❑	SPA 4	❑	SPA 8	❑
District 5	❑				

5. **Demographic Reflectiveness and Representation:**
Federal funders require that the Commission report the following demographic information annually to ensure its conformity with reflection/representation rules.

5a. **Gender:** ❑ Male ❑ Female ❑ Trans (Male to Female) ❑ Trans (Female to Male) ❑ Unknown

5b. **Race/Ethnicity:** (Check all that apply)
❑ African- American/Black,not Hispanic ❑ Hispanic
❑ American Indian/Alaska Native ❑ Multi-Race
❑ Anglo/White, not Hispanic ❑ Other :_______________
❑ Asian/ Pacific Islander ❑ Decline to State/Not Specified

5c. **Are you a parent/guardian/direct caregiver to a child with HIV under 19?** ❑ Yes ❑ No

6. **FOR APPLICANTS LIVING WITH HIV:**

6a. **Are you willing to publicly disclose your HIV status?** ❑ Yes* ❑ No
***DO NOT CHECK YES HERE if you do not want your HIV status known publicly. There is NO requirement that someone with HIV must disclose his/her status to the Commission or publicly.**

6b. **Age:** ❑ 13 – 19 years old ❑ 20 – 29 years old
❑ 30 – 39 years old ❑ 40 – 49 years old ❑ 50-59 years old
❑ 60+ years old ❑ Unknown

6c. **Are you a “consumer” (patient/client) of Ryan White Part A services?** ❑ Yes ❑ No

6d. **Are you “affiliated” with a Ryan White Part A-funded agency?** ❑ Yes ❑ No

By indicating “affiliated,” you are a: ❑ board member, ❑ employee, or ❑ consultant at the agency. A volunteer at an agency is considered an unaffiliated consumer.

Section 3: Experience/Knowledge

7. **Recommending Entities/Constituency(ies):** “Recommending Entities” are the individuals/ organizations who may have suggested or asked you to represent them on the Commission.

7a. **What organization/Who, if any/anyone, recommended you to the Commission?**

____

7b. **If recommended, what seat, if any, did he/she/they recommend you fill?**

____

8. **Please check all of the boxes that apply to you:**

1 ❑ I am willing to publicly disclose that I have Hepatitis B or C.
2 ❑ I am an HIV-negative user of HIV prevention services and who is a member of an identified high-risk, special or highly impacted population.
3 ❑ I am a member of a federally-recognized American Indian tribe or Native Alaskan village.
4 ❑ I am a behavioral or social scientist who is active in research from my respective field.
5 ❑ I am involved in HIV-related research in the following capacity(ies) (Check all that apply):
❑ scientist, lead researcher or PI, ❑ staff member, ❑ study participant, or ❑ IRB member.
6 ❑ A health or hospital planning agency has recommended that I fill that seat on the Commission.
7 ❑ I am an HIV specialty physician or an Infectious Disease (ID) doctor with HIV- positive patients.
8 ❑ The agency where I am employed provides mental health services.
9 ❑ The agency where I am employed provides substance abuse services.
10 ❑ The agency where I am employed is a provider of HIV care/treatment services.
11 ❑ The agency where I am employed is a provider of HIV prevention services.
12 ❑ The agency where I am employed is provider of ❑ housing and/or ❑ homeless services.
13 ❑ The agency where I am employed has HIV programs funded by Federal sources (other than Ryan White).
14 ❑ I work for or am otherwise affiliated with a health care provider that is a Federally Qualified Health Center (FQHC) or a Community Health Clinic (CHC).
15 ❑ As someone who is employed as an advocate for incarcerated PWLH and/or as a PWLH who has been incarcerated in the past three years, I can represent the interests of incarcerated PWLH.
16 ❑ I am able to represent the interests of Ryan White Part C grantees.
17 ❑ I am able to represent the interests of Ryan White Part D grantees.
18 ❑ I am able to represent the interests of Ryan White Part F grantees given my affiliation with:
❑ one of LA County’s AETC grantees/sub-grantees ❑ a HRSA SPNS grantee
❑ Part F dental reimbursement provider ❑ HRSA-contracted TA vendor
19 ❑ As an HIV community stakeholder, I have experience and knowledge given my affiliation with:
(Check all that apply)
❑ union or labor interests
❑ provider of employment or training services
❑ faith-based entity providing HIV services
❑ organization providing harm reduction services
❑ an organization engaged in HIV-related research
❑ the business community
❑ local elementary-/secondary-level education agency
❑ youth-serving agency, or as a youth.

9. **Training Requirements:** The Commission requires all members to complete the following trainings, which can be fulfilled if the trainings were provided by other institutions. Applicants will not be penalized for no prior training, but must take it once appointed.

9a. **Have you completed an "Introduction to HIV/STI,""HIV/STI 101," or a related basic informational HIV/STI training before? (If so, include Certificate of Completion; if not, the Commission provides the training)** ❑ Yes ❑ No

9b. **Have you completed a Health Insurance Portability and Accountability Act (HIPAA) training before?** (If so, please include Certificate of Completion; if not, the Commission will provide the training) ❑ Yes ❑ No

9c. **Have you completed a "Protection of Human Research Subjects" training before?** (If so, please include Certificate of Completion; if not, the Commission will provide the training) ❑ Yes ❑ No

Section 4: Biographical Information

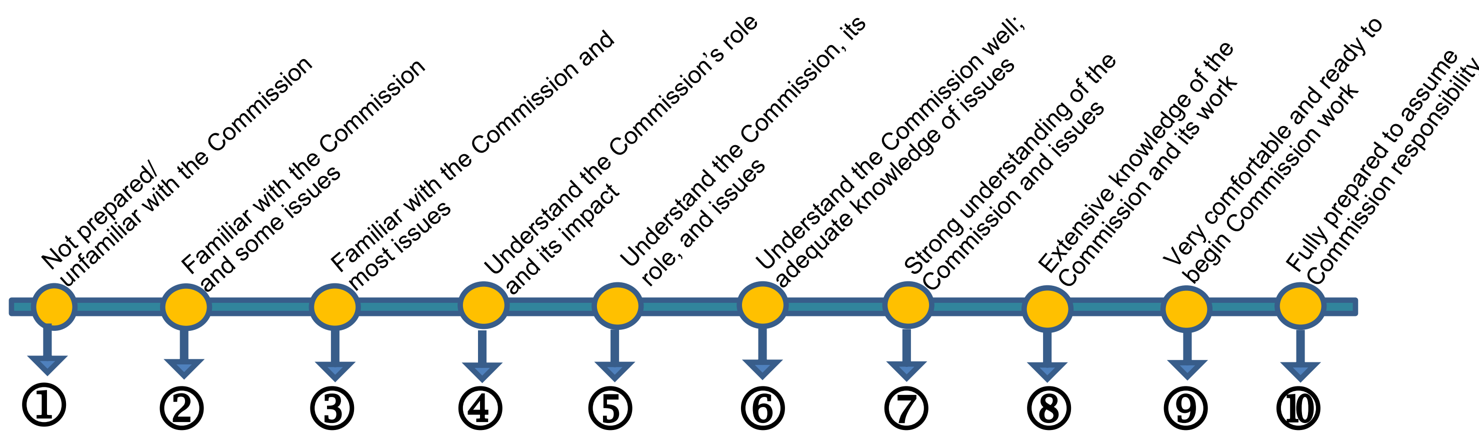
10. **Personal Statement:** The "personal statement" is a snapshot of your goals of your Commission participation, against which you can measure your effectiveness as a Commission member. This statement may be included on the Commission's website in the member section. Provide a short (50-word maximum) statement expressing why you want to be a Commission member:

11. **Biography/Resume**: If you would like, you can indicate below that you are updating this section from your original or renewal application, or simply write a new paragraph. You may—but it is not required—attach a new/updated resume. You may continue on an additional page, if necessary. As you feel appropriate, please provide a short biography detailing your background, and how it has prepared you for service on the Commission:

12. **Additional Information**: In this section, please provide any additional information about yourself—or update information from your original or renewal application—that you feel will enhance the application review. If you choose not to include any additional information, indicate it here with "N/A". Your additional information may continue on an additional page, if necessary:

Section 5: New Member Applicant (Only to be completed by new member applicant)

13. **How prepared do you feel you are to serve as a member of the Commission, if appointed?** A candidate's "preparedness" for Commission service is assessed—for this response—according to the 10-point scale located on the next page, which indicates that those who are the "least" prepared ("1" on the scale) are "not familiar" with the Commission and the issues that it reviews. The more prepared a candidate is—as indicated on the scale (moving towards "10" from "1")—s/he should demonstrate increased familiarity with the Commission and its content, evolving into "understanding" and "comfort" with the role of the Commission and its practices, and "limited" to "extensive" knowledge about the topics it addresses. Mark the circle that represents where you feel you fall on this scale of "preparedness" ("1" is "not prepared" ➡ "10," "fully prepared")



14. **Describe any personal/professional experience that you believe has prepared you to perform effectively as a member of the Commission. Continue on an additional page if necessary.**

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15. **What do you anticipate your greatest hurdles will be acclimating to your new role on the Commission? How do you think you will overcome them? Continue on an additional page if necessary.**

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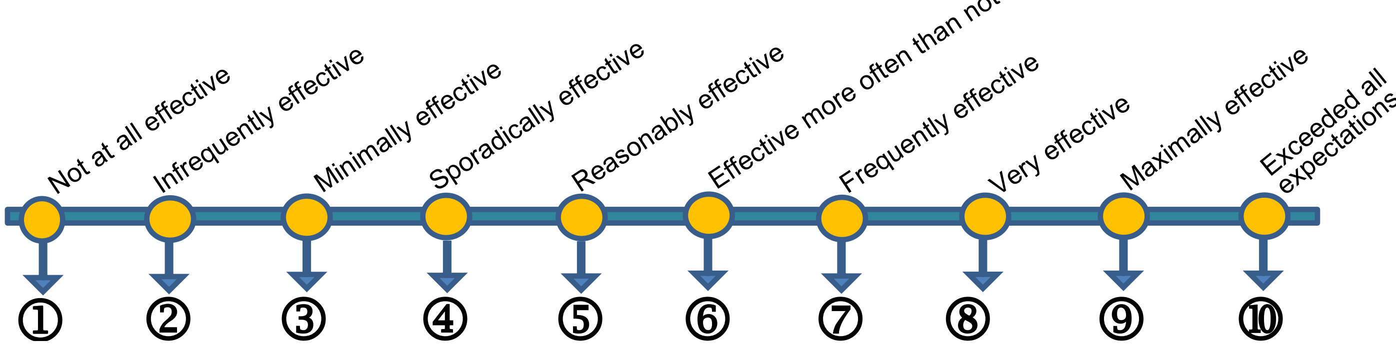
16. **How will your Commission membership benefit the lives of LA County residents with HIV/STDs and/or who are at high-risk of HIV-/STD-infection? Continue on an additional page if necessary.**

17. **Which of your strengths do you feel will enhance your Commission performance? What skills will you need to develop further for optimal Commission performance? Continue on an additional page if necessary.**

18. **Candidates are also nominated to fill Alternate seats as well: if you were nominated for an Alternate seat, would you be willing to serve in that capacity?** ❑ Yes ❑ No

Section 6: Renewal Applicant (Only to be completed by renewal applicant)

19. **How effective do you feel you were during your most recent term on the Commission?** Mark the circle that you feel is the best assessment of your Commission participation and engagement in the last term (1 is least effective ➡ 10 is most effective)



20. **Explain why you rated yourself the way you did in Question #16. Continue on an additional page, if necessary.**

21. **In your last term, what would you have done differently and what would you have improved, if anything (e.g., quality, communication skills, participation)?** Continue on an additional page, if necessary..

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22. **In your last term, what, if any, barriers and/or obstacles prevented you from fully carrying out your Commission responsibilities as you would have liked?** Continue on an additional page, if necessary.

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23. **What can the Commission do to help improve your effectiveness and/or level of contribution/accomplishment in your next term?** Continue on an additional page, if necessary.

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24. **Candidates are also nominated to fill Alternate seats as well: if you were nominated for an Alternate seat, would you be willing to serve in that capacity?**

Get in touch: hivcomm@lachiv.org

Virtual Training Schedule for Commissioners and Community Members

These trainings are **highly recommended.** The Ryan White HIV/AIDS Program Part A Manual stipulates the provision of a thorough orientation to new and returning planning council members and ongoing formal training to attain skills necessary to perform their duties.

September 2 @ 2pm to 3:30pm REGISTER HERE: https://tinyurl.com/y4rdbl6u	**Commission on HIV (COH) Overview** | Learn about the purpose of the COH, its ordinance and bylaws, and structure. Learn about integrated HIV prevention and care community planning.
September 14 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yxnnleq5	**Ryan White CARE Act Legislation Overview** | Learn about the landmark law that establishes lifesaving care for people living with HIV in the United States.
October 1 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yyl8gu9r	**Membership Structure and Responsibilities |** Learn about the duties of a Commissioner, the 51 seats on the body, and the functions of the Operations Committee. Learn how different member perspectives help facilitate a sound integrated HIV/STD prevention and care planning process. Understand the concepts of Parity, Inclusion, Reflectiveness, and Representation.
October 29 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yyhgv8sb	**Priority Setting and Resource Allocation (PSRA) Process |** Ryan White HIV/AIDS Program resources are limited and need is severe. Learn about the responsibility of planning councils to use sound information and a rational decision-making process when deciding which services and other program categories are priorities (priority setting) and how much to fund them (resource allocation).
November 5 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/y3c7f632	**Service Standards Development Process** | Learn why the COH develops service standards for HIV services, the functions of the Standards and Best Practices Committee, and how community members help shape standards of care in Los Angeles County.
November 19 @ 10am to 11:30am REGISTER HERE: https://tinyurl.com/yyh64om6	**Policy Priorities and Legislative Docket Development Process** | Learn about the functions of the Public Policy Committee and how the COH's policy priorities and legislative positions are developed. Learn about the Board of Supervisors guidance for Commissions on taking positions on legislative bills.

SUMMARY - RWP EXPENDITURE REPORT
As of November 5, 2020

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
RYAN WHITE PART A, MAI YEAR 30 AND PART B YR 2 (2020) EXPENDITURES BY SERVICE CATEGORIES

1	2	3	4	5	6
SERVICE CATEGORY	TOTAL FULL YEAR ESTIMATED EXPENDITURES PART A AND MAI	TOTAL FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL FULL YEAR ESTIMATED EXPENDITURES (Total Columns 2+3)	COH 2020 ALLOCATION PERCENTAGE APPLIED TO GRANT AWARD DIRECT SRVC PLUS PART B DIRECT SRVC	VARIANCE BETWEEN ALLOCATED BUDGETS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 5 - 4)
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 7,771,456	$ -	$ 7,771,456	$ 9,584,184	$ 1,812,728
MEDICAL CASE MGMT (Medical Care Coordination)	$ 12,239,257	$ -	$ 12,239,257	$ 10,513,048	$ (1,726,209)
ORAL HEALTH CARE	$ 4,864,791	**$ -**	$ 4,864,791	$ 4,960,976	$ 96,185
MENTAL HEALTH	$ 363,459	$ -	$ 363,459	$ 211,105	$ (152,354)
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 2,799,923	$ -	$ 2,799,923	$ 2,346,788	$ (453,135)
EARLY INTERVENTION SERVICES (HIV Testing Services)	$0	$ -	$ -	$ 207,587	$ 207,587
NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services and Transitional Case Management)	$ 1,916,408	**$ -**	$ 1,916,408	$ 2,291,134	$ 374,726
HOUSING (RCFCI, TRCF, and Permanent Supportive)	$ 3,172,138	$ 3,659,279	$ 6,831,417	$ 7,397,513	$ 566,096
OUTREACH (Linkage and Re-engagement Program and Partner Services)	$ 751,855	$ -	$ 751,855	$ 1,959,762	$ 1,207,907
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ 1,013,850	$ 1,013,850	$ 785,200	$ (228,650)
MEDICAL TRANSPORTATION	$ 503,260	**$ -**	$ 503,260	$ 664,982	$ 161,722
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 3,026,341	**$ -**	$ 3,026,341	$ 2,093,462	$ (932,879)
LEGAL	$ 115,197	$ -	$ 115,197	$ 56,295	$ (58,902)
SUB-TOTAL DIRECT SERVICES	$ 37,524,085	$ 4,673,129	$ 42,197,214	$ 43,072,036	$ 874,822
QUALITY MANAGEMENT	767,163	-	767,163	$ 1,330,192	$ -
ADMINISTRATIVE SERVICES	4,433,910	500,000	4,933,910	$ 4,933,971	$ (61)
GRAND TOTAL	**$ 42,725,158**	**$ 5,173,129**	**$ 47,898,287**	**$ 49,336,199**	**$ 1,437,912**
GRAND TOTAL PLUS $285,908 MAI YR 29 Carryover	**$ 42,725,158**	**$ 5,173,129**	**$ 47,898,287**	**$ 49,622,107**	**$ 1,723,820**

RYAN WHITE PART A SUMMARY

DRAFT

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
SUMMARY REPORT
GRANT YEAR 30 RYAN WHITE PART A FUNDING EXPENDITURES THROUGH FEBRUARY 2021 (as of Nov 5, 2020 and invoicing up to September 2020)

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	PART A COH ALLOCATIONS	PART A TOTAL YTD EXPENDITURES	PART A FULL YEAR EXPENDITURES	VARIANCE BETWEEN COH ALLOCATIONS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE	27.24%	4,207,919	7,771,456	$ 1,812,728
4	MEDICAL CASE MGMT (Medical Care Coordination)	29.88%	6,145,911	12,239,257	$ (1,726,209)
11	ORAL HEALTH CARE	14.10%	2,402,627	4,864,791	$ 96,185
3	MENTAL HEALTH	0.60%	206,184	363,459	$ (152,354)
16	HOME AND COMMUNITY BASED HEALTH SERVICES	6.67%	1,398,938	2,799,923	$ (453,135)
7	EARLY INTERVENTION SERVICES (HIV Testing Services)	0.59%	0	0	$ 207,587
10	NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services)	5.92%	759,535	1,280,587	$ 802,319
2	HOUSING (RCFCI, TRCF)	1.42%	398,871	468,871	$ 30,745
5	OUTREACH SERVICES (Linkage and Re-engagement Program and Partner Services)	5.57%	252,870	751,855	$ 1,207,907
15	SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	0.00%	0	0	$ -
9	MEDICAL TRANSPORTATION	1.89%	191,382	503,260	$ 161,722
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	5.95%	1,689,905	3,026,341	$ (932,879)
21	LEGAL	0.16%	976	115,197	$ (58,902)
	SUB-TOTAL DIRECT SERVICES	**100%**	**17,655,118**	**34,184,997**	**$ 995,715**
	QUALITY MANAGEMENT	1,330,192	275,643	767,163	$ 563,029
	ADMINISTRATION (Includes COH Budget) (10% of Part A award)	4,057,158	2,787,071	4,057,097	$ 61
	GRAND TOTAL	**$ 40,571,580**	**$ 20,717,832**	**$ 39,009,257**	**$ 1,562,323**

Year 30 Grant funding for Part A is $40,571,580

* Early Intervention Services - PHI staff salary transfers updated through Sept. 2019

RYAN WHITE MAI SUMMARY

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

GRANT YEAR 30 RYAN WHITE MAI FUNDING EXPENDITURES THROUGH FEBRUARY 2021 (as of Nov 5, 2020 and invoicing up to September 2020)

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	TOTAL ALLOCATION MAI FY 30	MAI FISCAL YEAR 30 TOTAL YTD EXPENDITURES	MAI FISCAL YEAR 30 FULL YEAR EXPENDITURES	VARIANCE BETWEEN COH ALLOCATIONS AND TOTAL FULL YEAR ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE	0.00%			$ -
4	MEDICAL CASE MGMT (Medical Care Coordination)	0.00%			$ -
11	ORAL HEALTH CARE	0.00%			$ -
3	MENTAL HEALTH	0.00%			$ -
16	HOME AND COMMUNITY BASED HEALTH SERVICES	0.00%			$ -
7	EARLY INTERVENTION SERVICES (HIV Testing Services)	0.00%			$ -
10	NON-MEDICAL CASE MANAGEMENT (Transitional Case Management)	6.14%	366,739	635,821	$ (427,594)
2	HOUSING (Permanent Supportive Housing/Housing for Health Program)	93.86%	1,351,633	2,703,267	$ 479,830
5	OUTREACH (Linkage and Re-engagement Program and Partner Services)	0.00%			$ -
15	SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	0.00%			$ -
9	MEDICAL TRANSPORTATION	0.00%			$ -
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	0.00%			$ -
21	LEGAL	0.00%			$ -
	SUB-TOTAL DIRECT SERVICES	100%	**1,718,372**	**3,339,088**	**$ 52,236**
	ADMINISTRATION (10% of MAI Year 30 award)	376,813	188,629	376,813	$ -
	GRAND TOTAL	**$ 3,768,137**	**$ 1,907,001**	**$ 3,715,901**	**$ 52,236**

The total MAI funding for Year 30 is $3,768,137 plus $285,908 from Year 29 approved roll over funding. However, this table only reflects the base award without the carryover funds

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

GRANT YEAR 30 RYAN WHITE PART B FUNDING EXPENDITURES THROUGH MARCH 2021 (as of Nov 5, 2020 and invoicing up to September 2020)

1	2	3	4	5	6
PRIORITY RANKING	SERVICE CATEGORY	PART B BUDGET	PART B TOTAL YTD EXPENDITURES	PART B FULL YEAR ESTIMTED EXPENDITURES	VARIANCE TOTAL BUDGET VS. FULL YR. ESTIMATED EXPENDITURES (Columns 3-5)
1	OUTPATIENT/AMBULATORY MEDICAL CARE				$ -
4	MEDICAL CASE MGMT SVCS (Medical Care Coordination)				$ -
11	ORAL HEALTH CARE				$ -
3	MENTAL HEALTH				$ -
16	HOME AND COMMUNITY BASED HEALTH SERVICES				$ -
7	EARLY INTERVENTION SERVICES (HIV Testing Services)				$ -
10	NON-MEDICAL CASE MANAGEMENT (Benefits Specialty Services and Transitional Case Management)				$ -
2	HOUSING (RCFCI, TRCF)	3,714,800	1,829,640	3,659,279	$ 55,521
5	OUTREACH (Linkage and Re-engagement Program and Partner Services)				$ -
15	SUBSTANCE ABUSE TREATMENT- RESIDENTIAL	785,200	506,925	1,013,850	$ (228,650)
9	MEDICAL TRANSPORTATION				$ -
13	FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT				$ -
21	LEGAL				$ -
	SUB-TOTAL DIRECT SERVICES	**$ 4,500,000**	**$ 2,336,565**	**$ 4,673,129**	$ (173,129)
	QUALITY MANAGEMENT	$ -	$ -	$ -	$ -
	ADMINISTRATION (10% of Part B award)	$ 500,000	$ 202,386	$ 500,000	$ -
	GRAND TOTAL	**$ 5,000,000**	**$ 2,538,951**	**$ 5,173,129**	**$ (173,129)**

Year 2 State allocation for Part B is $5,000,000.

FESIA A. DAVENPORT
Acting Chief Executive Officer

County of Los Angeles
CHIEF EXECUTIVE OFFICE

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

JANICE HAHN
Fourth District

KATHRYN BARGER
Fifth District

September 22, 2020

To: Supervisor Kathryn Barger, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Janice Hahn

From: Fesia A. Davenport
Acting Chief Executive Officer

REPORT ON ESTABLISHING AN ANTI-RACIST LOS ANGELES COUNTY POLICY AGENDA (ITEM NO. 3, AGENDA OF JULY 21, 2020)

On July 21, 2020, the Board of Supervisors (Board) adopted a motion to establish an Anti-Racist County Policy Agenda, recognizing, affirming, and declaring that "racism is a matter of public health in Los Angeles County (County) and that racism against Black people has reached crisis proportions that result in large disparities in family stability, health and mental wellness, education, employment, economic development, public safety, criminal justice, and housing." The Board issued several related directives, including that the Chief Executive Office (CEO) "establish an eighth Board Directed Priority to address the elimination of racism and bias in the County," and: a) develop a strategic plan and underlying policy platform articulating the associated goals, actions, and deliverables; b) establish an organizational unit within the CEO that is dedicated to implementing the plan; and c) report back to the Board on the strategic plan and policy platform within 60 days.

This report is our response to the Board motion's directive for a 60-day report, and presents the essential components and initial framework for developing a strategic plan and policy platform for moving forward the Board's Anti-Racist County Policy Agenda and, more specifically, for establishing a new *Anti-Racism, Diversity and Equity Initiative* (Initiative) within the CEO.

<u>Context for Establishing an *Anti-Racism, Diversity and Equity Initiative*</u>

The Board's July 21, 2020 motion stated that "[i]t is no longer sufficient to support diversity and inclusion initiatives. The County must move to identify and confront explicit institutional racism to set the national standard and become a leader of anti-racist policy making and program implementation."

The Board's directive, therefore, recognizes the injurious nature of systemic and institutionalized racism; it is so entrenched that it often goes unrecognized and its impacts are easily disregarded. As a result, while diversity and inclusion initiatives remain important, supporting diversity and inclusion alone is no longer sufficient. Anti-racism will require the County to work proactively to change the policies, behaviors, and beliefs that perpetuate racism by identifying and addressing those policies and practices in those areas where the County has control or influence, such as County employment, contracting, and the provision of County services.

Building on and Maximizing Existing Efforts

To be effective, a strategic plan for the new *Anti-Racism, Diversity and Equity Initiative* must guide, govern, and increase the County's ongoing commitment to fighting systemic racism in the places the County can effectively reach. In areas where the County has limited direct influence, the County should focus on developing partnerships that further its commitment to fighting systemic racism. The County's anti-racist strategic focus must address inequity compounded over time, and focus on actions and outcomes that will produce real, transformative, and systemic change.

Under the Board's vision and leadership, the County has established several innovative efforts aimed at achieving equity and addressing existing social and economic disparities. These initiatives (the Office of Diversion and Reentry, Alternatives to Incarceration, Office of Violence Prevention, Center for Health Equity, and the Chief Sustainability Office) have moved the County toward more equitable practices.

While the County continues to expand its efforts to address disparities, there is an opportunity to develop a shared understanding of anti-racist principles to meet and maximize this moment. Thus, the *Anti-Racism Strategic Plan* will recommend trainings, convenings, and stakeholder meetings to identify, refine, and develop critical strategies that will culminate in an *Anti-Racism, Diversity and Equity Initiative* for the County.

Anti-Racism Strategic Plan: Preliminary Steps and Proposed Framework

Given the urgent nature of the motion, the CEO launched a national search for an Executive Director of Racial Equity on September 11, 2020, with priority being given to applications received by September 28, 2020. Additionally, to create a platform for engagement and outreach, an Anti-Racism, Diversity and Inclusion Initiative website was created where content will be added as the Initiative takes shape. The CEO has created a phased framework to implement the motion's directives that will ultimately result in the development of an *Anti-Racism Strategic Plan.* The framework consists of four phases: Initialize, Mobilize, Operationalize, and Realize. Based on the CEO's initial fact-finding efforts, we also developed preliminary actions to capitalize on existing equity efforts and to set the stage for the strategic planning process described in our proposed framework. Although the action items in the framework are designed to be phased-in, any opportunities for executing items sooner than scheduled will be explored as they arise.

Conclusion and Next Steps

The eradication of structural racism is of utmost importance for the County. Consistent with the vision laid out by the Board in its motion on July 21, 2020, the CEO will:

- Begin implementing the phased strategic planning process outlined above, with the goal of having a completed *Anti-Racism Strategic Plan* by the end of the third phase ("Operationalize"); and

- Begin to implement and make operational an eighth Board Directed Priority to address the elimination of racism and bias in Los Angeles County, with the aim of helping the County become an actively anti-racist organization, and working to apply an anti-racist lens to review, develop, adjust, deconstruct, and reconstruct County procedures, policies, and practices accordingly.

The CEO will provide a status report on the implementation of the Initiative by June 30, 2021. In the interim, we will also assess existing resources in the County and determine their ability to be repurposed, leveraged or otherwise used to advance the *Anti-Racism Strategic Plan,* and present our recommendations as part of the Recommended Budget Phase.

Should you have any questions concerning this matter, please contact me or Tiana Murillo, Assistant Chief Executive Officer, at (213) 974-1186 or TMurillo@ceo.lacounty.gov.

FAD:JMN:TJM
EDT:RB:LJ:km

Attachment

c: Executive Office, Board of Supervisors
County Counsel

ATTACHMENT

Preliminary Steps and Anti-Racism Strategic Plan Framework Phases

Preliminary Steps Underway

1. **Establishing the Anti-Racism Leadership Committee,** comprised of the CEO and the departments of Human Resources; Workforce Development, Aging and Community Services/Human Relations Commission; co-leads of each workgroup referenced in number seven below; and others (e.g., Alternatives to Incarceration, the Center for Health Equity, the Chief Sustainability Office, Los Angeles Homeless Service Authority, the Office of Diversion and Reentry, Office of Child Protection, Center for Strategic Partnership, and the Office of Violence Prevention). The Committee will coordinate and drive County resources toward the development of an *Anti-Racism Strategic Plan* for Los Angeles County.

2. **Scheduling a Philanthropic/Academic Meeting** to inform the County's efforts to: a) address systemic racism through the sharing of best practices from the field; b) consult on strategies/metrics being developed for the *Anti-Racism Strategic Plan;* and c) advise on the development of the County's future Annual Report on the *State of Black Los Angeles County.*

3. **Collaborating with Government Alliance on Race and Equity (GARE)** to provide training, coaching, technical assistance, and strategic counsel on national best practices, as part of the strategic planning process for advancing racial equity in the County.

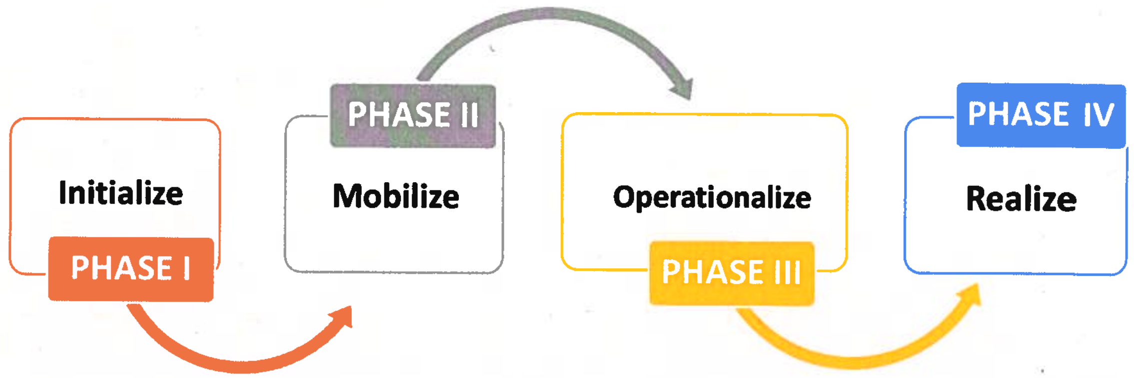
4. **Developing Countywide Core Committees** to develop/implement departmental and Countywide anti-racism and racial equity goals/objectives.

5. **Strategizing with the CEO's Office of Intergovernmental Affairs** and organizing a workgroup to identify legislative opportunities and develop recommendations to support the implementation of the County's *Anti-Racism Strategic Plan* and reduce racial disparities.

6. **Scheduling Additional Race Equity Community Forums** to inform the *Anti-Racism Strategic Plan* in areas such as, the digital divide, economic development, and employment.

7. **Convening Four Race Equity Internal Workgroups (Assessment and Metrics, Contracts and Procurement, Communty Partnerships, and Personnel and Training)** to discuss the Board motion and assign specific directives for implementation. A key role of the Workgroups will be to take the policies, programs, and procedures (PPPs) analysis and recommendations completed by the departments and weave them into an integrated tapestry of Countywide PPPs to be included in the *Anti-Racism Strategic Plan.*

Preliminary Steps and Anti-Racism Strategic Plan Framework Phases



Phase I: Initialize

1. **Establish an eighth Board-directed Priority** to address the elimination of racism and bias in the County.
2. **Respond to the Urban Institute's *Upward Mobility Request for Information*.** If successful, the County would receive 18 months of customized technical assistance to develop policies that address inequities and support upward mobility from poverty.
3. **Convene philanthropic/academic and community partnership workgroups.**
4. **Convene internal Racial Equity workgroups** to implement the Board motion's directives.
5. **Convene a workgroup to develop guiding principles (Mission/Vision/Goals)** for the strategic planning process.
6. **Develop a set of data/metrics** to establish baselines and measure future progress.
7. **Draft a Countywide community engagement process** for vetting the analysis and recommendations developed during Phase II.
8. **Expand functions of the County's *Anti-Racism, Diversity and Inclusion* Website** to enhance community engagement in the *Race Equity Strategic Planning process.*
9. **Develop a Race Equity training plan** for leadership/workgroup representatives, in consultation with GARE, on race equity and how to use a standardized race equity tool (race equity lens) for conducting an analysis of Countywide and departmental PPPs.
10. **Adopt a GARE Survey** to gather information on County employees' understanding of race and help to inform the strategic planning process.
11. **Develop a mandatory *Anti-Racism, Diversity and Equity Training Plan*** for County employees.

Preliminary Steps and Anti-Racism Strategic Plan Framework Phases

Phase II: Mobilize

1. **Complete analysis** and develop recommendations for changing departmental and Countywide PPPs to address systemic and structural racism, and other inequities based on the race equity analysis completed.
2. **Engage community/stakeholders** to discuss findings and receive input regarding the draft recommendations developed.
3. **Incorporate community input/finalize recommendations.**
4. **Launch Mandatory *Anti-Racism, Diversity and Equity Training Plan*** for County employees.
5. **Provide guidance for County Department Heads** on developing Anti-Racism, Diversity and Equity Management Appraisal and Performance Program (MAPP) Goals for Fiscal Year (FY) 2021-22.
6. **Establishment of *Office of Anti-Racism, Diversity and Equity* within the CEO**, and task it with coordinating the implementation of the County's *Anti-Racism Strategic Plan*, as instructed by the Board.

Phase III: Operationalize

Present for the Board's consideration:

1. **The County's *Anti-Racism Strategic Plan.***
2. **The *Anti-Racism, Diversity and Equity Training Plan*** for County employees.
3. **A summary of Department Head *Anti-Racism, Diversity, and Equity* MAPP Goals** for FY 2021-22.
4. **Legislative recommendations** to support the implementation of the County's Anti-Racism Strategic Plan, reduce racial disparities, and support local, regional, State, and Federal initiatives that advance efforts to dismantle systemic racism.
5. **Recommendations for launching the first annual report** on the *State of Black Los Angeles County* by June 2022, as instructed by the Board.

Phase IV: Realize

Begin implementation of the first year of the *Anti-Racism Strategic Plan* and the recommendations approved by the Board during the previous quarter.

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DRAFT

AGING TASK FORCE RECOMMENDATIONS
(Updated 11/17/20)

Background: The Aging Task Force (ATF) was formed in February 2019 to address the broad health needs of those over 50 years living with HIV and long-term survivors. According the Health Resources and Service Administration (HRSA), the RWHAP client population is aging. Of the more than half a million clients served by RWHAP, 46.1 percent are aged 50 years and older and this continues to grow. While Ryan White clients in Los Angeles County show higher engagement and retention in care, and viral suppression rates, within the 50+ population there exists disparities by racial/ethnic, socioeconomic, geographic, and age groups stratification.

The ATF developed the following recommendations to the Commission on HIV, Division of HIV and STD Programs (DHSP) and other County and City partners to address the unique needs of this population. The term older adults refer to individuals who are age 50 and older.

Ongoing Research and Needs Assessment:

- Collaborate with universities, municipalities, and other agencies that may have existing studies on PLWH over 50 to establish a better understanding of the following issues:
  - Conduct additional analysis to understand why approximately 27% of new diagnoses among persons aged 50-59 and 36% of new diagnoses among person aged 60 and older were late diagnoses (Stage 3 – AIDS) suggesting long-time infection. This may reflect a missed opportunity for earlier testing as it seems likely that persons aged 50 and older may engage in more regular health care than younger persons. (Data Source: http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/2019Annual_HIV_Surveillance_Report_08202020_Final_revised_Sept2020.pdf)
  - Gather data on PLWH over 50 who are out of care or those who have dropped out of care to further understand barriers and service needs.
  - Conduct studies on the prevention and care needs of older adults.
  - Understand disparities in health outcomes within the 50+ population by key demographic data points such as race/ethnicity, gender, geographic area, and socioeconomic status.
  - Gather data on the impact of the aging process as PLWH over 50 reach older age brackets. Articulate distinct differences in older age groups.
  - Conduct deeper analysis on mental health, depression, isolation, polypharmacy and other co-morbidities that impact the quality of life of older adults living with HIV.

- Conduct analysis of best practices on serving older adults in non-HIV settings and adapt key strategies for a comprehensive and integrated model of care the population. Examples of best practices to explore are National Association of Area Offices on Aging (https://www.n4a.org/bestpractices) and Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, Growing Older: Providing Integrated Care for an Aging Population. HHS Publication No. (SMA) 16-4982. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.

Workforce and Community Education and Awareness:

- Educate the HIV workforce and community at large on ageism, stigma, and build a common understanding of definition of older adults, elders, aging process and long-term survivors.
- Educate the HIV workforce on HIV and aging, including but not limited to how to work with the non-profit sector to link seniors to health, social services, and HIV prevention and treatment services.
- Train the HIV workforce on diseases of aging, such as cardiovascular disease and osteoporosis and dementia, and equip staff with the knowledge and skills to properly assess and treat conditions that impact older adults.
- Train older adults on how to adapt to the new realities of seeking care as they progress in the age spectrum. Train the HIV workforce on how to develop and deliver classes to older adults with respect, compassion, and patience.
- Expand opportunities for employment among those over 50 who are able and willing to work.
- Provide training on the use of technology in managing and navigating their care among older adults.
- Collaborate with the AIDS Education Centers to train HIV service providers on becoming experts and specialists on caring for older adults with HIV.
- Collaborate with local resources and experts in providing implicit bias training to HIV service providers.

Expand HIV/STD Prevention and Care Services for Older Adults:

- Expand and develop service models that are tailored for the unique needs of PLWH over 50. Specifically, community members representing older adults living with HIV have identified ambulatory/outpatient medical, medical care coordination, and mental health as key services they need. Unify and coordinate care within a medical home and reduce referrals to specialty care, if appropriate.
- Integrate an annual patient medical records review by gerontologist for PLWH over 50 in the Medical Care Coordination and Ambulatory/Outpatient Medical programs. The annual medical records review should review care needs for mental health, polypharmacy, social support, mobility, and other markers of overall health and quality of life.
- Customize food/nutrition and physical activity and mobility services for the aging population. Remedial exercise and rehabilitation to maintain or regain muscle mass

may be needed for some older adults to help them remain in care and virally suppressed.

- Enhance the payment structure for services rendered to older adults living with HIV as they may require more frequent, longer, and more intensive and individualized medical visits and routine care to maintain their overall health as they progress in the age continuum.
- Expand supportive services, such as financial assistance, as incomes become more fixed in older age. As frailty increases with age, services should be customized by specific age groups.
- Address social isolation by supporting psychosocial and peer support groups designed for older adults. Leverage the work of agencies that already provide support groups for older adults and encourage the community to join or start a support group.
- Address technological support for older adults living with HIV as medical service modalities rely more and more electronic, virtual, and telehealth formats.
- Dedicate at least 15% of prevention funds to programming specifically tailored for individuals over 50. According to the California HIV Surveillance Report, persons over 50 accounted for 15% of all new infections. A similar trend is observed for Los Angeles County with about 13-14% of new HIV diagnoses occurring among persons aged 50 and older
- Address the lack of sexual health programs and social marketing efforts geared for older adults. Social marketing and educational campaigns on PrEP and Undetectable=Untransmittable (U=U) should include messages and images with older adults.
- Integrate programming for older adults in the use of Ending the HIV Epidemic funds in Los Angeles County. Schedule annual reports from the Division of HIV and STD Programs (DHSP) on how they are addressing HIV and aging.

General Comments:

- Collaborate with traditional senior services or physicians, or other providers who specialize in geriatrics and leverage their skills and expertise of those outside the HIV provider world.
- Ensure access to transportation and customize transportation services to the unique needs of older adults.
- Benefits specialists should be well versed in Medicare eligibility and services to assist those individuals who are aging with HIV
- Direct DHSP to start working with agencies that serve older adults such as the Los Angeles County Workforce Development, Aging and Community Services, City of Los Angeles Department of Aging, and DPH Office of Senior Health to coordinate and leverage services.
- Ensure robust and meaningful input from older adults living with HIV in Commission deliberations on HIV, STD and other health services.

Adopted by BAAC Task Force 10.26.20

Black African American Community Task Force Commitment Statement

The Black African American Community Task Force (BAAC) convened on April 30, 2019 to develop a progressive and inclusive agenda to address and provide recommendations to the Los Angeles County (LAC) Commission on HIV (COH) and Division of HIV and STD Programs (DHSP), on how to reduce and ultimately eliminate the disproportionate impact of HIV/AIDS and STIs[i] in all subsets of the Black/African-American (Black/AA) community by utilizing a community-wide mobilization effort.

With the full understanding that among **preventable, curable and medically manageable health conditions, Black/AA populations continue experience worse outcomes when compared with all other demographics across LAC, the BAAC aims to:**

- **Identify** strategies on how the COH can support Black/AA leaders and community stakeholders to end HIV in the Black/AA community
- **Identify** HIV prevention, care and treatment best practices in the Black/AA community
- **Identify** specific strategies to reduce HIV stigma in the Black/AA community

Who we are:

The BAAC 'Village' is comprised of community advocates, leaders and health care professionals. The diversity of both professional and life experience provides a unique opportunity to advise DHSP; and other bodies who serve Black/AA people, on process that ensures equitable allocation of funding and resources that will impact our people currently living with or at risk for HIV.

The BAAC actively focuses its efforts on equity, justice, and equality[ii] as the historical disparities in HIV morbidity and mortality is a direct reflection of unequal access to HIV prevention and treatment services. We believe equality requires the allocation of resources be proportionate to HIV incidence and prevalence. Equity considers the harmful impact of systemic racism, genderism, classism and misogyny[iii] and recognizes resource distribution will not by itself close the historic health gap between Black/AAs and non-Black/AAs.

Nothing about us without us!

The BAAC will continue to operate from a position of solidarity and strength. The BAAC recognizes that it is comprised of individuals who share a common bond being vested within the Black/AA HIV community. We fully recognize that member diversity may lead to differences in problem solving approaches, opinions and communication; which if unresolved, not celebrated, and unappreciated, can and will lead to a malfunctioning body. To remedy this, all members of the BAAC agree to a code of conduct exemplifying excellence, respect for self and other taskforce members and constructive methods of communication that honor and support our variety of viewpoints and opinions.

The BAAC is united in ensuring that the COH and DHSP is actively aware of disproportionate HIV/STI related outcomes by race, sex/gender, and class. We remain proactive in providing solutions that are constructed and discussed through an antiracist and antimisogynistic lens. The BAAC is unwilling to accept the current status quo that perpetuates continued lack of adequate medical care, support and well-being.

As a testament to our commitment to the betterment of the sexual health of Black/AA in Los Angeles County, the BAAC offered 14 general/overall recommendations and 9 population-specific recommendations for consideration by the COH and DHSP. We invite all caucuses, committees, and working group of the COH, and leadership of DHSP to embrace these comprehensive recommendations to guide the development and allocation of resources that impact the most marginalized communities of Black/AA people.

We consider these our truths and intentions respectfully submitted on behalf of the COH BAAC.

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[i] At year-end 2019, there were 52,004 persons living with diagnosed HIV (PLWH) in LAC. **Twenty percent (20%) of those individuals diagnosed with HIV were Black/AAs, while representing only 8% of the population in LAC**. (LAC HIV Surveillance Annual Report (2019), Division of HIV and STD Programs, LAC Department of Public Health.)

According to the LAC HIV Surveillance Annual Report (2019), there are continued disparities in HIV diagnosis by population. **Black men and women had higher rate of HIV diagnosis** compared with other race/ethnicity groups. **Populations with lowest achievements in linkage to care included Blacks/AAs. Treatment coverage was lowest for Blacks/AAs** while the **greatest disparities in viral suppression also included the Black/AA population.**

Acquired Immunodeficiency Syndrome (AIDS) is now called "stage 3" per the World Health Organization's 2010 disease progression classification, (https://journalofethics.ama-assn.org/article/who-clinical-staging-system-hivaids/2010-03). **In Los Angeles County, the highest rate of stage 3 (AIDS) diagnoses was among African Americans (18 per 100,000).** The rate of stage 3 diagnoses for **African American females (6 per 100,000)** was 9 times higher than the rate for white females (<1 per 100,000) and 3 times higher than the rate for Latinas (2 per 100,000). Among **males**, the rate of stage 3 diagnoses for **African Americans (32 per 100,000)** was 4 times higher than the rate for whites (9 per 100,000) and 3 times higher than the rate for Latinos (13 per 100,000).

[ii] **Equity** (defined as the quality of being fair and impartial. "equity of treatment"). **Equality** is defined as the condition of being equal, or the same in quality, measure, esteem or value. **Disparities** - a noticeable and usually significant difference. (https://www.merriam-webster.com/)

[iii] **Systemic racism** – Institutional racism, also known as systemic racism, is a form of racism that is embedded as normal practice within society or an organization. It can lead to such issues as discrimination in criminal justice, employment, housing, health care, political power, and education, among other issues. These systems can include laws and regulations, but also unquestioned social systems. Systemic racism can stem from education, hiring practices or access. (https://theconversation.com/explainer-what-is-systemic-racism-and-institutional-racism-131152)

Genderism – Genderism may refer to: Gender binary, the classification of gender into two distinct, opposite, and disconnected forms of masculine and feminine. Gender essentialism, the theory that universal features in social gender are at the root of all differences between men and women. The belief that gender is a binary, comprising male and female, and that the aspects of a person's gender are inherently linked to their sex at birth. (https://psychology.wikia.org/wiki/Genderism)

Classism – prejudice or discrimination based on social class or a biased or discriminatory attitude based on distinctions made between social or economic classes; the viewing of society as being composed of distinct classes. (https://www.nccj.org/classism-0)

Misogyny – hatred, dislike, or mistrust of women, manifested in various forms such as physical intimidation and abuse, sexual harassment and rape, social shunning and ostracism, etc. *The underlying misogyny in slut-shaming; historically witch hunts were an embodiment of the misogyny of the time.* Ingrained and institutionalized prejudice against women; sexism. (https://www.merriam-webster.com/dictionary/misogyny)